



General Assembly

January Session, 2015

Raised Bill No. 1023

LCO No. 4022



Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING REVISIONS TO THE HEALTH INSURANCE STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (a) of section 38a-183 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective from*
3 *passage*):

4 (a) (1) A health care center governed by sections 38a-175 to 38a-192,
5 inclusive, shall not enter into any agreement with subscribers unless
6 and until it has filed with the commissioner a full schedule of the
7 amounts to be paid by the subscribers and has obtained the
8 commissioner's approval thereof. Such filing shall include an actuarial
9 memorandum that includes, but is not limited to, pricing assumptions
10 and claims experience, and premium rates and loss ratios from the
11 inception of the contract or policy. The commissioner may refuse such
12 approval if [he] the commissioner finds such amounts to be excessive,
13 inadequate or discriminatory. As used in this subsection, "loss ratio"
14 means the ratio of incurred claims to earned premiums by the number
15 of years of policy duration for all combined durations.

16 (2) Premium rates offered to individuals shall be consistent with the
17 requirements set forth in section 38a-481, as amended by this act.

18 (3) Premium rates offered to small employers, as defined in section
19 38a-564, as amended by this act, shall be consistent with the
20 requirements set forth in section 38a-567, as amended by this act.

21 (4) [Each] No such health care center shall [not] enter into any
22 agreement with subscribers unless and until it has filed with the
23 commissioner a copy of such agreement or agreements, including all
24 riders and endorsements thereon, and until the commissioner's
25 approval thereof has been obtained. The commissioner shall, within a
26 reasonable time after the filing of any request for an approval of the
27 amounts to be paid, any agreement or any form, notify the health care
28 center of [either his] the commissioner's approval or disapproval
29 thereof.

30 Sec. 2. Section 38a-199 of the general statutes is repealed and the
31 following is substituted in lieu thereof (*Effective from passage*):

32 (a) A hospital service corporation is defined as a non-profit-sharing
33 corporation without capital stock organized under the laws of the state
34 for the purpose of establishing, maintaining and operating a plan
35 whereby comprehensive health care, [which shall include] that
36 includes inpatient and outpatient hospital care and home care,
37 provided and billed by an approved general, special or chronic disease
38 hospital, an approved clinic or an approved chronic and convalescent
39 nursing home, and services incidental thereto, may be provided, at the
40 expense of said corporation, to subscribers to such plan under a
41 contract entitling such subscribers to the benefits provided therein.
42 When so determined by any such corporation comprehensive health
43 care shall also include appliances, drugs, medicines, supplies and all
44 other health goods and services, including the services of physicians,
45 doctors of dentistry and other licensed practitioners of the healing arts.
46 Each such corporation shall be governed by sections 38a-199 to 38a-

47 209, inclusive, and shall, except as [specifically designated herein]
48 otherwise provided in this title, be exempt from the provisions of the
49 general statutes relating to insurance. The provisions of sections 38a-
50 815 to 38a-819, inclusive, except subdivision (9) of section 38a-816,
51 shall be applicable to such corporation. Such hospitals, clinics and
52 chronic and convalescent nursing homes as shall be contained in a list
53 of approved institutions maintained by the Department of Public
54 Health shall be deemed approved for the purposes of sections 38a-199
55 to 38a-209, inclusive.

56 (b) A hospital service corporation providing health care benefits to
57 plan subscribers under the provisions of subsection (a) of this section
58 may, upon obtaining the approval of the Insurance Commissioner as
59 provided in section 38a-208, as amended by this act: (1) [Adjust the
60 rates to be paid by any group or groups of its subscribers based upon
61 past and prospective loss experience and may classify subscribers and
62 groups of subscribers and determine rates with reference to standards
63 for variations or risks or expenses which it may establish; (2) contract]
64 Contract for the coordination of benefits with other hospital service
65 corporations, medical service corporations or insurance companies to
66 avoid duplication of benefits to be provided to its group subscribers;
67 [(3)] (2) make loans, grants or provide anything of value to a health
68 care center covering all or part of the cost of health services provided
69 to members; [(4)] (3) contract with a health care center to provide
70 insurance or similar protection to cover the cost of care provided
71 through health care centers and to provide coverage in the event of the
72 insolvency of the health care center; and [(5)] (4) establish, maintain,
73 own and operate health care centers as a line of business, provided that
74 (A) aggregate investments hereafter made by such corporation shall
75 not exceed ten per cent of such corporation's contingency reserve as of
76 the date of the investment; (B) such investments shall not be repaid or
77 recovered from rates charged by such corporation for its non-health-
78 care-center lines of business; and (C) the commissioner [shall find]
79 finds, based upon evidence furnished by such corporation, that the

80 financial condition of such corporation and the rates of its non-health-
81 care-center subscribers are not unduly jeopardized by such
82 investment. [Subdivisions (1) and (2)] Subdivision (2) of this subsection
83 shall be subject to such regulations as may be adopted by the
84 Insurance Commissioner, in accordance with the provisions of chapter
85 54, to establish [guidelines of eligibility for experience rating and
86 adoption of] coordination of benefits clauses in health care contracts.

87 (c) Each hospital service corporation shall maintain reserves equal in
88 amount to its liabilities under all its policy contracts, as the same are
89 computed in accordance with regulations [of the commissioner]
90 adopted in accordance with chapter 54 upon reasonable consideration
91 of ascertained experience for the purpose of adequately protecting the
92 subscriber and securing the solvency of such company. Each such
93 corporation shall maintain a reserve for contingencies [which] that
94 shall not be less than the amount required by companies licensed to
95 transact accident and health insurance, under section 38a-72. The
96 commissioner may adopt regulations, in accordance with the
97 provisions of chapter 54, prescribing the maximum amount that may
98 be held in the reserve for contingencies, and in adopting such
99 regulations, [he] shall consider the stability, solvency and interests of
100 the corporation and the interests of the subscribers and other affected
101 persons. [The commissioner shall allow a reasonable period of time for
102 compliance with this section, not to exceed five years.] On and after
103 October 1, 1974, the commissioner may require a hospital service
104 corporation to adjust its reserve for contingencies to comply with the
105 provisions of this section and to adjust its rates or benefits or both to
106 reflect the adjustment in the reserve for contingencies.

107 Sec. 3. Section 38a-208 of the general statutes is repealed and the
108 following is substituted in lieu thereof (*Effective from passage*):

109 (a) No such corporation shall enter into any contract with
110 subscribers unless and until it has filed with the Insurance
111 Commissioner a full schedule of the rates to be paid by the subscribers

112 and has obtained said commissioner's approval thereof. Such filing
113 shall include an actuarial memorandum that includes, but is not
114 limited to, pricing assumptions and claims experience, and premium
115 rates and loss ratios from the inception of the contract. The
116 commissioner may refuse such approval if [he] the commissioner finds
117 such rates to be excessive, inadequate or discriminatory. As used in
118 this subsection, "loss ratio" means the ratio of incurred claims to
119 earned premiums by the number of years of policy duration for all
120 combined durations.

121 (b) Premium rates offered to individuals shall be consistent with the
122 requirements set forth in section 38a-481, as amended by this act.

123 (c) Premium rates offered to small employers, as defined in section
124 38a-564, as amended by this act, shall be consistent with the
125 requirements set forth in section 38a-567, as amended by this act.

126 (d) No hospital service corporation shall enter into any contract with
127 subscribers unless and until it has filed with the Insurance
128 Commissioner a copy of such contract, including all riders and
129 endorsements thereof, and until said commissioner's approval thereof
130 has been obtained. The Insurance Commissioner shall, within a
131 reasonable time after the filing of any such form, notify such
132 corporation [either of his] of the commissioner's approval or
133 disapproval thereof.

134 Sec. 4. Section 38a-214 of the general statutes is repealed and the
135 following is substituted in lieu thereof (*Effective from passage*):

136 (a) A nonprofit medical service corporation is defined as a non-
137 profit-sharing corporation without capital stock organized under the
138 laws of the state for the purpose of establishing, maintaining and
139 operating a plan whereby comprehensive health care, [which shall
140 include] that includes inpatient and outpatient hospital care and home
141 care, provided and billed by an approved general, special or chronic
142 disease hospital, an approved clinic or an approved chronic and

143 convalescent nursing home and services incidental thereto may be
144 provided, at the expense of said corporation, to subscribers to such
145 plan under a contract entitling such subscribers to the benefits
146 provided therein. When so determined by any such corporation,
147 comprehensive health care shall also include appliances, drugs,
148 medicines, supplies and all other health goods and services, including
149 the services of physicians, doctors of dentistry and other licensed
150 practitioners of the healing arts. Any such corporation [which] that
151 provides coverage for the services of physicians shall also provide
152 coverage for the services of chiropractors licensed under chapter 372
153 and naturopaths licensed under chapter 373. Each such corporation
154 shall, except as [specifically designated herein] otherwise provided in
155 this title, be exempt from the provisions of the general statutes relating
156 to insurance. The provisions of sections 38a-815 to 38a-819, inclusive,
157 except subdivision (9) of section 38a-816, shall be applicable to such
158 corporation. Such hospitals, clinics and chronic and convalescent
159 nursing homes as shall be contained in a list of approved institutions
160 maintained by the Department of Public Health shall be deemed
161 approved for the purposes of sections 38a-214 to 38a-225, inclusive.

162 (b) A medical service corporation providing health care benefits to
163 plan subscribers under the provisions of subsection (a) of this section
164 may, upon obtaining the approval of the Insurance Commissioner as
165 provided in section 38a-218, as amended by this act: (1) [Adjust the
166 rates to be paid by any group or groups of its subscribers based upon
167 past and prospective loss experience and may classify subscribers and
168 groups of subscribers and determine rates with reference to standards
169 for variations of risks or expenses which it may establish; (2) contract]
170 Contract for the coordination of benefits with other hospital service
171 corporations, medical service corporations or insurance companies to
172 avoid duplication of benefits to be provided to its group subscribers;
173 [(3)] (2) make loans, grants or provide anything of value to a health
174 care center covering all or part of the cost of health services provided
175 to members; [(4)] (3) contract with a health care center to provide

176 insurance or similar protection to cover the cost of care provided
177 through health care centers and to provide coverage in the event of the
178 insolvency of the health care center; and [(5)] (4) establish, maintain,
179 own and operate health care centers as a line of business, provided that
180 (A) aggregate investments hereafter made by such corporation shall
181 not exceed ten per cent of such corporation's contingency reserve as of
182 the date of the investment; (B) such investments shall not be repaid or
183 recovered from rates charged by such corporation for its non-health-
184 care-center lines of business; and (C) the commissioner [shall find]
185 finds, based upon evidence furnished by such corporation, that the
186 financial condition of such corporation and the rates of its non-health-
187 care-center subscribers are not unduly jeopardized by such
188 investment. [Subdivisions (1) and] Subdivision (2) of this subsection
189 shall be subject to such regulations as may be adopted by the
190 Insurance Commissioner, in accordance with the provisions of chapter
191 54, to establish [guidelines of eligibility for experience rating and
192 adoption of] coordination of benefits clauses in health care benefit
193 contracts.

194 (c) Each medical service corporation shall maintain reserves equal in
195 amount to its liabilities under all its policy contracts, as the same are
196 computed in accordance with regulations [of the commissioner]
197 adopted in accordance with chapter 54 upon reasonable consideration
198 of ascertained experience for the purpose of adequately protecting the
199 subscriber or securing the solvency of such company. Each such
200 corporation shall maintain a reserve for contingencies [which] that
201 shall not be less than the amount required by companies licensed to
202 transact accident and health insurance, under section 38a-72. The
203 commissioner may adopt regulations, in accordance with the
204 provisions of chapter 54, prescribing the maximum amount that may
205 be held in the reserve for contingencies, and in adopting such
206 regulations, [he] shall consider the stability, solvency and interests of
207 the corporation, and the interests of the subscribers and other affected
208 persons. [The commissioner shall allow a reasonable period of time for

209 compliance with this section, not to exceed five years.] On and after
210 October 1, 1974, the commissioner may require a medical service
211 corporation to adjust its reserve for contingencies to comply with the
212 provisions of this section and to adjust its rates or benefits or both to
213 reflect such adjustment in the reserve for contingencies.

214 Sec. 5. Section 38a-218 of the general statutes is repealed and the
215 following is substituted in lieu thereof (*Effective from passage*):

216 (a) No such medical service corporation shall enter into any contract
217 with subscribers unless and until it has filed with the Insurance
218 Commissioner a full schedule of the rates to be paid by the subscriber
219 and has obtained said commissioner's approval thereof. Such filing
220 shall include an actuarial memorandum that includes, but is not
221 limited to, pricing assumptions and claims experience, and premium
222 rates and loss ratios from the inception of the contract. The
223 commissioner may refuse such approval if [he] the commissioner finds
224 such rates are excessive, inadequate or discriminatory. As used in this
225 subsection, "loss ratio" means the ratio of incurred claims to earned
226 premiums by the number of years of policy duration for all combined
227 durations.

228 (b) Premium rates offered to individuals shall be consistent with the
229 requirements set forth in section 38a-481, as amended by this act.

230 (c) Premium rates offered to small employers, as defined in section
231 38a-564, as amended by this act, shall be consistent with the
232 requirements set forth in section 38a-567, as amended by this act.

233 (d) No such medical service corporation shall enter into any contract
234 with subscribers unless and until it has filed with the Insurance
235 Commissioner a copy of such contract, including all riders and
236 endorsements thereof, and until said commissioner's approval thereof
237 has been obtained. The Insurance Commissioner shall, within a
238 reasonable time after the filing of any such form, notify such
239 corporation [either of his] of the commissioner's approval or

240 disapproval thereof.

241 Sec. 6. Section 38a-481 of the general statutes is repealed and the
242 following is substituted in lieu thereof (*Effective from passage*):

243 (a) No individual health insurance policy shall be delivered or
244 issued for delivery to any person in this state, nor shall any
245 application, rider or endorsement be used in connection with such
246 policy, until a copy of the form thereof and of the classification of risks
247 and the premium rates have been filed with the commissioner. Rate
248 filings shall include an actuarial memorandum that includes, but is not
249 limited to, pricing assumptions and claims experience, and premium
250 rates and loss ratios from the inception of the policy. The
251 commissioner shall adopt regulations, in accordance with the
252 provisions of chapter 54, to establish a procedure for reviewing such
253 policies. The commissioner shall disapprove the use of such form at
254 any time if it does not comply with the requirements of law, or if it
255 contains a provision or provisions [which] that are unfair or deceptive
256 or [which] that encourage misrepresentation of the policy. The
257 commissioner shall notify, in writing, the insurer [which] that has filed
258 any such form of the commissioner's disapproval, specifying the
259 reasons for disapproval, and ordering that no such insurer shall
260 deliver or issue for delivery to any person in this state a policy on or
261 containing such form. The provisions of section 38a-19 shall apply to
262 such orders. As used in this subsection, "loss ratio" means the ratio of
263 incurred claims to earned premiums by the number of years of policy
264 duration for all combined durations.

265 (b) No rate filed under the provisions of subsection (a) of this
266 section shall be effective until it has been [filed and] approved by the
267 commissioner in accordance with regulations adopted pursuant to this
268 subsection. The commissioner shall adopt regulations, in accordance
269 with the provisions of chapter 54, to prescribe standards to ensure that
270 such rates shall not be excessive, inadequate or unfairly
271 discriminatory. The commissioner may disapprove such rate [within

272 thirty days after it has been filed] if it fails to comply with such
273 standards, except that no rate filed under the provisions of subsection
274 (a) of this section for any Medicare supplement policy shall be effective
275 unless approved in accordance with section 38a-474.

276 (c) No insurance company, fraternal benefit society, hospital service
277 corporation, medical service corporation, health care center or other
278 entity [which] that delivers or issues for delivery in this state any
279 Medicare supplement policies or certificates shall incorporate in its
280 rates or determinations to grant coverage for Medicare supplement
281 insurance policies or certificates any factors or values based on the age,
282 gender, previous claims history or the medical condition of any person
283 covered by such policy or certificate.

284 (d) [For the purposes of this section, "loss ratio" means the ratio of
285 incurred claims to earned premiums by the number of years of policy
286 duration for all combined durations.] No individual health insurance
287 policy delivered, issued for delivery, renewed, amended or continued
288 in this state shall include any provision that reduces payments on the
289 basis that an individual is eligible for Medicare by reason of age,
290 disability or end-stage renal disease, unless such individual enrolls in
291 Medicare. If such individual enrolls in Medicare, any such reduction
292 shall be only to the extent such coverage is provided by Medicare.

293 (e) Nothing in this chapter shall preclude the issuance of an
294 individual health insurance policy that includes an optional life
295 insurance rider, provided the optional life insurance rider shall be filed
296 with and approved by the Insurance Commissioner pursuant to
297 section 38a-430. Any company offering such policies for sale in this
298 state shall be licensed to sell life insurance in this state pursuant to the
299 provisions of section 38a-41.

300 [(f) No insurance company, fraternal benefit society, hospital service
301 corporation, medical service corporation, health care center or other
302 entity that delivers, issues for delivery, amends, renews or continues

303 an individual health insurance policy in this state shall: (1) Move an
304 insured individual from a standard underwriting classification to a
305 substandard underwriting classification after the policy is issued; (2)
306 increase premium rates due to the claim experience or health status of
307 an individual who is insured under the policy, except that the entity
308 may increase premium rates for all individuals in an underwriting
309 classification due to the claim experience or health status of the
310 underwriting classification as a whole; or (3) use an individual's
311 history of taking a prescription drug for anxiety for six months or less
312 as a factor in its underwriting unless such history arises directly from a
313 medical diagnosis of an underlying condition.]

314 (f) Health insurance issued to an association or other insurance
315 arrangement that is not made up solely of employer groups shall be
316 treated as individual health insurance.

317 (g) (1) As used in this subsection, "Affordable Care Act" means the
318 Patient Protection and Affordable Care Act, P.L. 111-148, as amended
319 from time to time, and regulations adopted thereunder, and
320 "grandfathered plan" has the same meaning as "grandfathered health
321 plan" as provided in the Affordable Care Act.

322 (2) Each individual health insurance policy subject to the Affordable
323 Care Act shall be offered on a guaranteed issue basis with respect to all
324 eligible individuals or dependents.

325 (3) With respect to grandfathered plans of a policy under
326 subdivision (2) of this subsection, the premium rates charged or
327 offered shall be established on the basis of a single pool of all
328 grandfathered plans.

329 (4) With respect to nongrandfathered plans of a policy under
330 subdivision (2) of this subsection:

331 (A) The premium rates charged or offered shall be established on
332 the basis of a single pool of all nongrandfathered plans, adjusted to

333 reflect one or more of the following classifications:

334 (i) Age, in accordance with a uniform age rating curve established
335 by the commissioner;

336 (ii) Geographic area, as defined by the commissioner;

337 (iii) Tobacco use, except that such rate may not vary by a ratio of
338 greater than 1.5 to 1.0 and may only be applied with respect to
339 individuals who may legally use tobacco under state and federal law.
340 For purposes of this subparagraph, "tobacco use" means the use of
341 tobacco products four or more times per week on average within a
342 period not longer than the six months immediately preceding.
343 "Tobacco use" does not include the religious or ceremonial use of
344 tobacco;

345 (B) Total premium rates for family coverage shall be determined by
346 adding the premiums for each individual family member, except that
347 with respect to family members under twenty-one years of age, the
348 premiums for only the three oldest covered children shall be taken into
349 account in determining the total premium rate for such family.

350 (5) Premium rates for a grandfathered or nongrandfathered policy
351 under subdivision (2) of this subsection may vary by (A) actuarially
352 justified differences in plan design, and (B) actuarially justified
353 amounts to reflect the policy's provider network and administrative
354 expense differences that can be reasonably allocated to such policy.

355 Sec. 7. Subsections (a) and (b) of section 38a-513 of the general
356 statutes are repealed and the following is substituted in lieu thereof
357 (Effective from passage):

358 (a) (1) No group health insurance policy, as defined by the
359 commissioner, or certificate shall be [issued or] delivered or issued for
360 delivery in this state unless a copy of the form for such policy or
361 certificate has been submitted to and approved by the commissioner

362 under the regulations adopted pursuant to this section. The
363 commissioner shall adopt regulations, in accordance with the
364 provisions of chapter 54, concerning the provisions, submission and
365 approval of such policies and certificates and establishing a procedure
366 for reviewing such policies and certificates. [If the commissioner issues
367 an order disapproving the use of such form, the] The commissioner
368 shall disapprove the use of such form at any time if it does not comply
369 with the requirements of law, or if it contains a provision or provisions
370 that are unfair or deceptive or that encourage misrepresentation of the
371 policy. The commissioner shall notify, in writing, the insurer that has
372 filed any such form of the commissioner's disapproval, specifying the
373 reasons for disapproval, and ordering that no such insurer shall
374 deliver or issue for delivery to any person in this state a policy on or
375 containing such form. The provisions of section 38a-19 shall apply to
376 such order.

377 (2) No group health insurance policy or certificate for a small
378 employer, as defined in section 38a-564, as amended by this act, shall
379 be delivered or issued for delivery in this state unless the premium
380 rates have been submitted to and approved by the commissioner.
381 Premium rate filings shall include an actuarial memorandum that
382 includes, but is not limited to, pricing assumptions and claims
383 experience, and premium rates and loss ratios from the inception of
384 the policy. As used in this subdivision, "loss ratio" means the ratio of
385 incurred claims to earned premiums by the number of years of policy
386 duration for all combined durations.

387 (b) No insurance company, fraternal benefit society, hospital service
388 corporation, medical service corporation, health care center or other
389 entity [which] that delivers or issues for delivery in this state any
390 Medicare supplement policies or certificates shall incorporate in its
391 rates or determinations to grant coverage for Medicare supplement
392 insurance policies or certificates any factors or values based on the age,
393 gender, previous claims history or the medical condition of any person
394 covered by such policy or certificate.

395 Sec. 8. Section 38a-476 of the general statutes is repealed and the
396 following is substituted in lieu thereof (*Effective from passage*):

397 (a) [(1)] For the purposes of this section: [, "health insurance plan"]
398 (1) "Health insurance plan" means any hospital and medical expense
399 incurred policy, hospital or medical service plan contract and health
400 care center subscriber contract. [and] "Health insurance plan" does not
401 include (A) short-term health insurance issued on a nonrenewable
402 basis with a duration of six months or less, accident only, credit,
403 dental, vision, Medicare supplement, long-term care or disability
404 insurance, hospital indemnity coverage, coverage issued as a
405 supplement to liability insurance, insurance arising out of a workers'
406 compensation or similar law, automobile medical payments insurance,
407 or insurance under which beneficiaries are payable without regard to
408 fault and which is statutorily required to be contained in any liability
409 insurance policy or equivalent self-insurance, or (B) policies of
410 specified disease or limited benefit health insurance, provided that the
411 carrier offering such policies files on or before March first of each year
412 a certification with the Insurance Commissioner that contains the
413 following: (i) A statement from the carrier certifying that such policies
414 are being offered and marketed as supplemental health insurance and
415 not as a substitute for hospital or medical expense insurance; (ii) a
416 summary description of each such policy including the average annual
417 premium rates, or range of premium rates in cases where premiums
418 vary by age, gender or other factors, charged for such policies in the
419 state; and (iii) in the case of a policy that is described in this
420 subparagraph and that is offered for the first time in this state on or
421 after October 1, 1993, the carrier files with the commissioner the
422 information and statement required in this subparagraph at least thirty
423 days prior to the date such policy is issued or delivered in this state.

424 (2) "Insurance arrangement" means any "multiple employer welfare
425 arrangement", as defined in Section 3 of the Employee Retirement
426 Income Security Act of 1974, as amended from time to time, except for
427 any such arrangement [which] that is fully insured within the meaning

428 of Section 514(b)(6) of said act, as amended from time to time.

429 (3) "Preexisting conditions provision" means a policy provision
430 [which] that limits or excludes benefits relating to a condition based on
431 the fact that the condition was present before the effective date of
432 coverage, for which any medical advice, diagnosis, care or treatment
433 was recommended or received before such effective date. Routine
434 follow-up care to determine whether a breast cancer has reoccurred in
435 a person who has been previously determined to be breast cancer free
436 shall not be considered as medical advice, diagnosis, care or treatment
437 for purposes of this section unless evidence of breast cancer is found
438 during or as a result of such follow-up. Genetic information shall not
439 be treated as a condition in the absence of a diagnosis of the condition
440 related to such information. Pregnancy shall not be considered a
441 preexisting condition.

442 [(4) "Qualifying coverage" means (A) any group health insurance
443 plan, insurance arrangement or self-insured plan, (B) Medicare or
444 Medicaid, or (C) an individual health insurance plan that provides
445 benefits which are actuarially equivalent to or exceeding the benefits
446 provided under the small employer health care plan, as defined in
447 subdivision (12) of section 38a-564, whether issued in this state or any
448 other state.]

449 [(5)] (4) "Applicable waiting period" means the period of time
450 imposed by the group policyholder or contractholder before an
451 individual is eligible for participating in the group policy or contract.

452 (b) (1) No group health insurance plan or insurance arrangement
453 shall impose a preexisting conditions provision [that excludes
454 coverage for (A) individuals eighteen years of age and younger, or (B)
455 a period beyond twelve months following the insured's effective date
456 of coverage. Any preexisting conditions provision shall only relate to
457 conditions, whether physical or mental, for which medical advice,
458 diagnosis or care or treatment was recommended or received during

459 the six months immediately preceding the effective date of coverage]
460 on any individual.

461 (2) No individual health insurance plan or insurance arrangement
462 shall impose a preexisting conditions provision [that excludes
463 coverage for (A) individuals eighteen years of age and younger, or (B)
464 a period beyond twelve months following the insured's effective date
465 of coverage. Any preexisting conditions provision shall only relate to
466 conditions, whether physical or mental, for which medical advice,
467 diagnosis or care or treatment was recommended or received during
468 the twelve months immediately preceding the effective date of
469 coverage] on any individual.

470 (3) No insurance company, fraternal benefit society, hospital service
471 corporation, medical service corporation or health care center shall
472 refuse to issue an individual health insurance plan or insurance
473 arrangement to [individuals eighteen years of age and younger] any
474 individual solely on the basis that [an] such individual has a
475 preexisting condition.

476 [(c) All health insurance plans and insurance arrangements shall
477 provide coverage, under the terms and conditions of their policies or
478 contracts, for the preexisting conditions of any newly insured
479 individual who was previously covered for such preexisting condition
480 under the terms of the individual's preceding qualifying coverage,
481 provided the preceding coverage was continuous to a date less than
482 one hundred twenty days prior to the effective date of the new
483 coverage, exclusive of any applicable waiting period, except in the case
484 of a newly insured group member whose previous coverage was
485 terminated due to an involuntary loss of employment, the preceding
486 coverage must have been continuous to a date not more than one
487 hundred fifty days prior to the effective date of the new coverage,
488 exclusive of any applicable waiting period, provided such newly
489 insured group member or dependent applies for such succeeding
490 coverage within thirty days of the member's or dependent's initial

491 eligibility.

492 (d) With respect to a newly insured individual who was previously
493 covered under qualifying coverage, but who was not covered under
494 such qualifying coverage for a preexisting condition, as defined under
495 the new health insurance plan or arrangement, such plan or
496 arrangement shall credit the time such individual was previously
497 covered by qualifying coverage to the exclusion period of the
498 preexisting condition provision, provided the preceding coverage was
499 continuous to a date less than one hundred twenty days prior to the
500 effective date of the new coverage, exclusive of any applicable waiting
501 period under such plan, except in the case of a newly insured group
502 member whose preceding coverage was terminated due to an
503 involuntary loss of employment, the preceding coverage must have
504 been continuous to a date not more than one hundred fifty days prior
505 to the effective date of the new coverage, exclusive of any applicable
506 waiting period, provided such newly insured group member or
507 dependent applies for such succeeding coverage within thirty days of
508 the member's or dependent's initial eligibility.

509 (e) Each insurance company, fraternal benefit society, hospital
510 service corporation, medical service corporation or health care center
511 which issues in this state group health insurance subject to Section
512 2701 of the Public Health Service Act, as set forth in the Health
513 Insurance Portability and Accountability Act of 1996 (P.L. 104-191)
514 (HIPAA), as amended from time to time, shall comply with the
515 provisions of said section with respect to such group health insurance,
516 except that the longer period of days specified in subsections (c) and
517 (d) of this section shall apply to the extent excepted from preemption
518 in Section 2723(B)(2)(iii) of said Public Health Service Act.

519 (f) The provisions of this section shall apply to every health
520 insurance plan or insurance arrangement issued, renewed or
521 continued in this state on or after October 1, 1993. For purposes of this
522 section, the date a plan or arrangement is continued shall be the

523 anniversary date of the issuance of the plan or arrangement. The
524 provisions of subsection (e) of this section shall apply on and after the
525 dates specified in Sections 2747 and 2792 of the Public Health Service
526 Act as set forth in HIPAA.]

527 [(g)] (c) (1) Notwithstanding the provisions of subsection (a) of this
528 section, a short-term health insurance policy issued on a nonrenewable
529 basis for six months or less [which] that imposes a preexisting
530 conditions provision shall be subject to the following conditions: [(1)]
531 (A) No such preexisting conditions provision shall exclude coverage
532 beyond twelve months following the insured's effective date of
533 coverage; [(2)] (B) such preexisting conditions provision may only
534 relate to conditions, whether physical or mental, for which medical
535 advice, diagnosis, care or treatment was recommended or received
536 during the twenty-four months immediately preceding the effective
537 date of coverage; and [(3)] (C) any policy, application or sales brochure
538 issued for such short-term health insurance policy that imposes such
539 preexisting conditions provision shall disclose in a conspicuous
540 manner in not less than fourteen-point bold face type the following
541 statement:

542 "THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR
543 WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT
544 WAS RECOMMENDED OR RECEIVED DURING THE TWENTY-
545 FOUR MONTHS IMMEDIATELY PRECEDING THE EFFECTIVE
546 DATE OF COVERAGE."

547 (2) In the event an insurer or health care center issues two
548 consecutive short-term health insurance policies on a nonrenewable
549 basis for six months or less [which imposes] that impose a preexisting
550 conditions provision to the same individual, the insurer or health care
551 center shall reduce the preexisting conditions exclusion period in the
552 second policy by the period of time such individual was covered under
553 the first policy. If the same insurer or health care center issues a third
554 or subsequent such short-term health insurance policy to the same

555 individual, such insurer or health care center shall reduce the
556 preexisting conditions exclusion period in the third or subsequent
557 policy by the cumulative time covered under the prior policies.
558 Nothing in this section shall be construed to require such short-term
559 health insurance policy to be issued on a guaranteed issue or
560 guaranteed renewable basis.

561 [(h) The commissioner may adopt regulations, in accordance with
562 the provisions of chapter 54, to enforce the provisions of HIPAA and
563 this section concerning preexisting conditions and portability.]

564 Sec. 9. Subsection (a) of section 38a-478g of the general statutes is
565 repealed and the following is substituted in lieu thereof (*Effective from*
566 *passage*):

567 (a) Each managed care contract delivered, issued for delivery,
568 renewed, amended or continued in this state shall be in writing and a
569 copy thereof furnished to the group contract holder or individual
570 contract holder, as appropriate. Each such contract shall contain the
571 following provisions: (1) Name and address of the managed care
572 organization; (2) eligibility requirements; (3) a statement of
573 copayments, deductibles or other out-of-pocket expenses the enrollee
574 must pay; (4) a statement of the nature of the health care services,
575 benefits or coverages to be furnished and the period during which they
576 will be furnished and, if there are any services, benefits or coverages to
577 be excepted, a detailed statement of such exceptions; (5) a statement of
578 terms and conditions upon which the contract may be cancelled or
579 otherwise terminated at the option of either party; (6) claims
580 procedures; (7) enrollee grievance procedures; (8) continuation of
581 coverage; (9) [conversion; (10)] extension of benefits, if any; [(11)] (10)
582 subrogation, if any; [(12)] (11) description of the service area, and out-
583 of-area benefits and services, if any; [(13)] (12) a statement of the
584 amount the enrollee or others on his behalf must pay to the managed
585 care organization and the manner in which such amount is payable;
586 [(14)] (13) a statement that the contract includes the endorsement

587 thereon and attached papers, if any, and contains the entire contract;
 588 [(15)] (14) a statement that no statement by the enrollee in his
 589 application for a contract shall void the contract or be used in any legal
 590 proceeding thereunder, unless such application or an exact copy
 591 thereof is included in or attached to such contract; and [(16)] (15) a
 592 statement of the grace period for making any payment due under the
 593 contract, which shall not be less than ten days. The commissioner may
 594 waive the requirements of this subsection for any managed care
 595 organization subject to the provisions of section 38a-182.

596 Sec. 10. Section 38a-505 of the general statutes is repealed and the
 597 following is substituted in lieu thereof (*Effective from passage*):

598 In order to provide reasonable simplification of terms and coverages
 599 of individual health insurance policies, to facilitate public
 600 understanding and comparison, to eliminate provisions [which] that
 601 may be misleading or unreasonably confusing in connection with
 602 either the purchase of such coverage or with the settlement of claims
 603 and to provide for full disclosure in the sale of such coverages:

604 [(a)] (1) The commissioner shall [issue] adopt regulations, in
 605 accordance with the provisions of chapter 54, to establish specific
 606 standards for policy provisions used in individual health insurance
 607 policies, [but not including group conversion policies, which] that shall
 608 be in addition to and in accordance with sections 38a-80, 38a-321 to
 609 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
 610 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
 611 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
 612 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, and other
 613 applicable laws of this state [which] that may cover the terms of
 614 renewability, initial and subsequent conditions of eligibility,
 615 nonduplication of coverage provisions, coverage of dependents,
 616 termination of insurance, probationary periods, limitations, exceptions,
 617 reductions, elimination periods, requirements for replacements,
 618 recurrent conditions, preexisting conditions, and the definition of the

619 terms hospital, accident, sickness, injury, physician, accidental means,
620 total disability, permanent disability, partial disability, nervous
621 disorders, guaranteed renewable [,] and noncancellable.

622 [(b)] (2) The commissioner shall adopt regulations, in accordance
623 with chapter 54, that specify prohibited policy provisions not
624 otherwise specifically authorized by statute [which] that in the opinion
625 of the commissioner are unjust, unfair or unfairly discriminatory to the
626 policyholder, any person insured under the policy [,] or any
627 beneficiary.

628 [(c)] (3) The commissioner shall adopt regulations, in accordance
629 with chapter 54, to establish minimum standards for benefits under
630 each of the following categories of coverage in individual policies: [,
631 other than conversion policies issued pursuant to a contractual
632 conversion privilege under a group policy:] Basic hospital expense
633 coverage, basic medical-surgical expense coverage, hospital
634 confinement indemnity coverage, major medical expense coverage,
635 disability income protection coverage, accident only coverage,
636 specified accident coverage and specified disease coverage.

637 [(d)] (4) Nothing in this section shall preclude the issuance of any
638 policy [which] that combines two or more of the categories of coverage
639 enumerated in [subsection (c)] subdivision (3) of this section, except
640 that specified accident coverage shall not be combined with any other
641 category of coverage. The commissioner shall prescribe the method of
642 identification of policies based upon coverage provided.

643 [(e)] (5) No policy shall be delivered or issued for delivery in this
644 state [which] that does not meet the prescribed minimum standards for
645 the categories of coverage listed in [subsection (c)] subdivision (3) of
646 this section, provided nothing in this section shall preclude the
647 issuance or delivery of any policy [which] that does not meet such
648 prescribed minimum standards of coverage so long as such policy is
649 clearly identified as not meeting such prescribed standards.

650 [(f)] (6) No such policy shall be delivered in this state unless: [(1)]
 651 (A) An outline of coverage described herein accompanies the policy or
 652 [(2)] (B) the outline of coverage described in this section is delivered to
 653 the applicant at the time application is made and acknowledgment of
 654 receipt of certificate of delivery of such outline is provided the carrier
 655 with the application. In the event the policy is issued on a basis other
 656 than that applied for, the outline of coverage properly describing the
 657 policy shall accompany the policy when it is delivered. The outline of
 658 coverage shall include: [(A)] (i) A statement identifying the applicable
 659 category or categories of coverage provided by the policy in
 660 accordance with this section; [(B)] (ii) a description of the principal
 661 benefits and coverage provided in the policy; [(C)] (iii) a statement of
 662 the exceptions, reductions and limitations contained in the policy or
 663 contract; [(D)] (iv) a statement of the renewal provisions including any
 664 reservation by the carrier of a right to change premiums; and [(E)] (v) a
 665 statement that the outline is a summary of the policy issued or applied
 666 for and that the policy should be consulted to determine governing
 667 contractual provisions.

668 [(g)] Notwithstanding the provisions of sections 38a-80, 38a-321 to
 669 38a-324, inclusive, 38a-326, 38a-329, 38a-334 to 38a-336a, inclusive, 38a-
 670 338 to 38a-358, inclusive, 38a-470 to 38a-472, inclusive, 38a-475, 38a-480
 671 to 38a-503, inclusive, 38a-507, 38a-514, 38a-519, 38a-523, 38a-531, 38a-
 672 577 to 38a-590, inclusive, and 38a-802 to 38a-810, inclusive, if a carrier
 673 elects to use a simplified application form, with or without any
 674 questions as to the applicant's health at the time of application, but
 675 without any questions concerning the insured's health history or
 676 medical treatment history, the policy shall cover loss developing after
 677 twelve months from any preexisting condition not specifically
 678 excluded from coverage by the terms of the policy and, except as so
 679 provided, the policy shall not include wording that would permit a
 680 defense based upon preexisting conditions.]

681 [(h)] (7) Regulations promulgated pursuant to this section shall
 682 specify an effective date applicable to policy and benefit riders

683 delivered or issued for delivery in this state on and after such effective
684 date [which] that shall not be less than one hundred eighty days after
685 the date of adoption or promulgation.

686 Sec. 11. Section 38a-512a of the general statutes is repealed and the
687 following is substituted in lieu thereof (*Effective from passage*):

688 (a) (1) Each insurer, health care center, hospital service corporation,
689 medical service corporation, fraternal benefit society or other entity
690 delivering, issuing for delivery, renewing, amending or continuing a
691 group health insurance policy in this state that provides coverage of
692 the type specified in subdivisions (1), (2), (3), (4), (11) and (12) of
693 section 38a-469 shall provide the option to continue coverage under
694 each of the following circumstances until the individual is eligible for
695 other group insurance, except as provided in subparagraphs (C) and
696 (D) of this subdivision:

697 (A) Upon layoff, reduction of hours, leave of absence or termination
698 of employment, other than as a result of death of the employee or as a
699 result of such employee's "gross misconduct" as that term is used in 29
700 USC 1163(2), continuation of coverage for such employee and such
701 employee's covered dependents for a period of thirty months after the
702 date of such layoff, reduction of hours, leave of absence or termination
703 of employment, except that if such reduction of hours, leave of absence
704 or termination of employment results from an employee's eligibility to
705 receive Social Security income, continuation of coverage for such
706 employee and such employee's covered dependents until midnight of
707 the day preceding such person's eligibility for benefits under Title
708 XVIII of the Social Security Act;

709 (B) Upon the death of the employee, continuation of coverage for
710 the covered dependents of such employee for the periods set forth for
711 such event under federal extension requirements established by the
712 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
713 as amended from time to time;

714 (C) Regardless of the employee's or dependent's eligibility for other
715 group insurance, during an employee's absence due to illness or injury,
716 continuation of coverage for such employee and such employee's
717 covered dependents during continuance of such illness or injury or for
718 up to twelve months from the beginning of such absence;

719 (D) Regardless of an individual's eligibility for other group
720 insurance, upon termination of the group policy, coverage for covered
721 individuals who were totally disabled on the date of termination shall
722 be continued without premium payment during the continuance of
723 such disability for a period of twelve calendar months following the
724 calendar month in which such policy was terminated, provided claim
725 is submitted for coverage within one year of the termination of such
726 policy;

727 (E) The coverage of any covered individual shall terminate: (i) As to
728 a child, (I) as set forth in section 38a-512b. If on the date specified for
729 termination of coverage on a child, the child is incapable of self-
730 sustaining employment by reason of mental or physical handicap and
731 chiefly dependent upon the employee for support and maintenance,
732 the coverage on such child shall continue while the plan remains in
733 force and the child remains in such condition, provided proof of such
734 handicap is received by such insurer, center, corporation, society or
735 other entity within thirty-one days of the date on which the child's
736 coverage would have terminated in the absence of such incapacity.
737 Such insurer, center, corporation, society or other entity may require
738 subsequent proof of the child's continued incapacity and dependency
739 but not more often than once a year thereafter, or (II) for the periods
740 set forth for such child under federal extension requirements
741 established by the Consolidated Omnibus Budget Reconciliation Act of
742 1985, P.L. 99-272, as amended from time to time; (ii) as to the
743 employee's spouse, at the end of the month following the month in
744 which a divorce, court-ordered annulment or legal separation is
745 obtained, whichever is earlier, except that the plan shall provide the
746 option for said spouse to continue coverage for the periods set forth for

747 such events under federal extension requirements established by the
748 Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272,
749 as amended from time to time; and (iii) as to the employee or
750 dependent who is sixty-five years of age or older, as of midnight of the
751 day preceding such person's eligibility for benefits under Title XVIII of
752 the federal Social Security Act;

753 (F) As to any other event listed as a "qualifying event" in 29 USC
754 1163, as amended from time to time, continuation of coverage for such
755 periods set forth for such event in 29 USC 1162, as amended from time
756 to time, provided such plan may require the individual whose
757 coverage is to be continued to pay up to the percentage of the
758 applicable premium as specified for such event in 29 USC 1162, as
759 amended from time to time.

760 (2) Any continuation of coverage required by this subsection except
761 subparagraph (D) or (F) of subdivision (1) of this subsection may be
762 subject to the requirement, on the part of the individual whose
763 coverage is to be continued, that such individual contribute that
764 portion of the premium the individual would have been required to
765 contribute had the employee remained an active covered employee,
766 except that the individual may be required to pay up to one hundred
767 two per cent of the entire premium at the group rate if coverage is
768 continued in accordance with subparagraph (A), (B) or (E) of
769 subdivision (1) of this subsection. The employer shall not be legally
770 obligated by section 38a-505, as amended by this act, or 38a-546 to pay
771 such premium if not paid timely by the employee.

772 [(b) The plan shall make available to Connecticut residents, in
773 addition to any other conversion privilege available, a conversion
774 privilege under which coverage shall be available immediately upon
775 termination of coverage under the group policy. The terms and
776 benefits offered under the conversion benefits shall be at least equal to
777 the terms and benefits of an individual health insurance policy.]

778 [(c)] (b) Nothing in this section shall alter or impair existing group
779 policies [which] that have been established pursuant to an agreement
780 [which] that resulted from collective bargaining, and the provisions
781 required by this section shall become effective upon the next regular
782 renewal and completion of such collective bargaining agreement.

783 Sec. 12. Section 38a-537 of the general statutes is repealed and the
784 following is substituted in lieu thereof (*Effective from passage*):

785 (a) Any individual, partnership, corporation, or unincorporated
786 association providing group health insurance coverage for its
787 employees shall furnish each insured employee, upon cancellation or
788 discontinuation of such health insurance, notice of the cancellation or
789 discontinuation of such insurance. The notice shall be mailed or
790 delivered to the insured employee not less than fifteen days next
791 preceding the effective date of cancellation or discontinuation. Any
792 individual or any such entity that fails to provide timely notice shall be
793 fined not more than two thousand dollars for each violation. The Labor
794 Commissioner shall have the authority to assess all such fines. This
795 section shall apply to any such individual, partnership, corporation or
796 unincorporated association that substitutes one policy providing
797 group health insurance coverage for another such policy with no
798 interruption in coverage.

799 (b) If any individual or any such entity fails to furnish notice
800 pursuant to subsection (a) of this section, the individual or entity shall
801 be liable for benefits to the same extent as the insurer, hospital or
802 medical service corporation or health care center would have been
803 liable if coverage had not been cancelled or discontinued.

804 (c) Any individual, partnership, corporation, or unincorporated
805 association which makes deductions from an employee's wages for
806 group health insurance coverage and fails to procure such coverage
807 shall be liable for benefits to the same extent as the insurer, hospital or
808 medical service corporation or health care center would have been

809 liable if coverage had been procured. If any corporation makes
810 deductions from an employee's wages for group health insurance
811 coverage and fails to procure such coverage, any officer of the
812 corporation responsible for procuring such coverage for employees
813 who wilfully failed to procure such coverage shall be personally liable
814 for benefits to the same extent as the insurer, hospital or medical
815 service corporation or health care center would have been liable if
816 coverage had been procured, provided that personal liability shall only
817 be imposed against the officer in the event that an amount owed an
818 employee due to the officer's failure cannot otherwise be collected
819 from the corporation itself.

820 [(d) Whenever an employer ceases doing business, any terminated
821 employee whose group health insurance was discontinued on or
822 before the date of termination of employment and who did not receive
823 notice of such discontinuation pursuant to subsection (a) of this section
824 shall be eligible for ninety days from the date of discontinuation to
825 purchase as a conversion privilege an individual comprehensive health
826 care plan for himself and any dependents covered by the discontinued
827 group health insurance plan from the former insurer, hospital or
828 medical service corporation, health care center or the Health
829 Reinsurance Association, if any insurer is not issuing such coverage,
830 with coverage retroactive to the date of discontinuation. The employee
831 shall pay the premiums for the period of retroactive coverage. No
832 retroactive coverage may be purchased for a period during which the
833 employee is eligible for benefits under another group plan.]

834 Sec. 13. Section 38a-551 of the general statutes is repealed and the
835 following is substituted in lieu thereof (*Effective from passage*):

836 For the purposes of this section and sections 38a-552, as amended by
837 this act, and 38a-556 to 38a-559, inclusive, as amended by this act, the
838 following terms [shall] have the following meanings:

839 [(a)] (1) "Health insurance" or "health care plan" means hospital and

840 medical expenses incurred policies written on a direct basis, nonprofit
841 service plan contracts, health care center contracts and self-insured or
842 self-funded employee health benefit plans. [For purposes of sections
843 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "health insurance"]
844 "Health insurance" or "health care plan" does not include [(1)] (A)
845 accident only, credit, dental, vision, Medicare supplement, long-term
846 care or disability insurance, hospital indemnity coverage, coverage
847 issued as a supplement to liability insurance, insurance arising out of a
848 workers' compensation or similar law, automobile medical-payments
849 insurance, or insurance under which beneficiaries are payable without
850 regard to fault and which is statutorily required to be contained in any
851 liability insurance policy or equivalent self-insurance, or [(2)] (B)
852 policies of specified disease or limited benefit health insurance,
853 provided: [(A)] (i) The carrier offering such policies files on or before
854 March first of each year a certification with the commissioner that
855 contains the following: [(i)] (I) A statement from the carrier certifying
856 that such policies are being offered and marketed as supplemental
857 health insurance and not as a substitute for hospital or medical
858 expense insurance; and [(ii)] (II) a summary description of each such
859 policy including the average annual premium rates, or range of
860 premium rates in cases where premiums vary by age, gender or other
861 factors, charged for such policy in the state; and [(B)] (ii) for each such
862 policy that is offered for the first time in this state on or after July 1,
863 2005, the carrier files with the commissioner the information and
864 statement required in subparagraph [(A)] (B)(i) of this subdivision at
865 least thirty days prior to the date such policy is issued or delivered in
866 this state.

867 [(b)] (2) "Carrier" means an insurer, health care center, hospital
868 service corporation or medical service corporation or fraternal benefit
869 society.

870 [(c)] (3) "Insurer" means an insurance company licensed to transact
871 accident and health insurance business in this state.

872 [(d)] (4) "Health care center" [means a health care center, as defined]
873 has the same meaning as provided in section 38a-175.

874 [(e)] (5) "Self-insurer" or "self-insured or self-funded employee
875 health benefit plan" means an employer or an employee welfare
876 benefit fund or plan [which] that provides payment for or
877 reimbursement of the whole or any part of the cost of covered hospital
878 or medical expenses for covered individuals. [For purposes of sections
879 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, "self-insurer" shall]
880 "Self-insurer" or "self-insured or self-funded employee health benefit
881 plan" does not include any such employee welfare benefit fund or plan
882 established prior to April 1, 1976, by any organization [which] that is
883 exempt from federal income taxes under the provisions of Section 501
884 of the United States Internal Revenue Code and amendments thereto
885 and legal interpretations thereof, except any such organization
886 described in Subsection (c)(15) of said Section 501.

887 [(f)] (6) "Commissioner" means the Insurance Commissioner. [of the
888 state of Connecticut.]

889 [(g)] "Physician" means a doctor of medicine, chiropractic,
890 naturopathy, podiatry, a qualified psychologist and, for purposes of
891 oral surgery only, a doctor of dental surgery or a doctor of medical
892 dentistry and, subject to the provisions of section 20-138d, optometrists
893 duly licensed under the provisions of chapter 380.

894 (h) "Qualified psychologist" means a person who is duly licensed or
895 certified as a clinical psychologist and has a doctoral degree in and at
896 least two years of supervised experience in clinical psychology in a
897 licensed hospital or mental health center.

898 (i) "Skilled nursing facility" has the same meaning as "skilled
899 nursing facility", as defined in Section 1395x, Chapter 7 of Title 42,
900 United States Code.

901 (j) "Hospital" has the same meaning as "hospital", as defined in

902 Section 1395x, Chapter 7 of Title 42, United States Code.

903 (k) "Home health agency" has the same meaning as "home health
904 agency", as defined in Section 1395x, Chapter 7 of Title 42, United
905 States Code.

906 (l) "Copayment" means the portion of a charge that is covered by a
907 plan and not payable by the plan and which is thus the obligation of
908 the covered individual to pay.]

909 [(m)] (Z) "Resident employer" means any person, partnership,
910 association, trust, estate, limited liability company, corporation,
911 whether foreign or domestic, or the legal representative, trustee in
912 bankruptcy or receiver or trustee, thereof, or the legal representative of
913 a deceased person, including the state of Connecticut and each
914 municipality therein [, which] that has in its employ one or more
915 individuals during any calendar year, commencing January 1, 1976.
916 [For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559,
917 inclusive, the term "resident employer" shall refer] "Resident
918 employer" refers only to an employer with a majority of employees
919 employed within the state of Connecticut.

920 [(n) "Eligible employee" means, with respect to any employer, an
921 employee who either is considered a full-time employee, or who is
922 expected to work at least twenty hours a week for at least twenty-six
923 weeks during the next twelve months or who has actually worked at
924 least twenty hours a week for at least twenty-six weeks in any
925 continuous twelve-month period.

926 (o) "Alcoholism treatment facility" has the same meaning as
927 provided in section 38a-533.

928 (p) "Totally disabled" means with respect to an employee, the
929 inability of the employee because of an injury or disease to perform the
930 duties of any occupation for which he is suited by reason of education,
931 training or experience, and, with respect to a dependent, the inability

932 of the dependent because of an injury or disease to engage in
933 substantially all of the normal activities of persons of like age and sex
934 in good health.

935 (q) "Deductible" means the amount of covered expenses that must
936 be accumulated during each calendar year before benefits become
937 payable as additional covered expenses incurred.

938 (r) For purposes of sections 38a-505, 38a-546 and 38a-551 to 38a-559,
939 inclusive, "disease or injury" shall include pregnancy and resulting
940 childbirth or miscarriage.

941 (s) "Complications of pregnancy" means (1) conditions requiring
942 hospital stays, when the pregnancy is not terminated, whose diagnoses
943 are distinct from pregnancy but are adversely affected by pregnancy or
944 are caused by pregnancy, such as acute nephritis, nephrosis, cardiac
945 decompensation, missed abortion and similar medical and surgical
946 conditions of comparable severity, and shall not include false labor,
947 occasional spotting, physician-prescribed rest during the period of
948 pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia
949 and similar conditions associated with management of a difficult
950 pregnancy not constituting a nosologically distinct complication of
951 pregnancy; and (2) nonelective caesarean section, ectopic pregnancy
952 which is terminated, and spontaneous termination of pregnancy,
953 which occurs during a period of gestation in which a viable birth is not
954 possible.]

955 [(t)] (8) "Resident" means [(1) a person] an individual who maintains
956 a residence in this state for a period of at least one hundred eighty
957 days. [, or (2) a HIPAA or health care tax credit eligible individual who
958 maintains a residence in this state.]

959 [(u) "HIPAA eligible individual" means an eligible individual as
960 defined in subsection (b) of section 2741 of the Public Health Service
961 Act, as set forth in the Health Insurance Portability and Accountability
962 Act of 1996 (P.L. 104-191) (HIPAA).

963 (v) "Health care tax credit eligible individual" means a person who
964 is eligible for the credit for health insurance costs under Section 35 of
965 the Internal Revenue Code of 1986 in accordance with the Pension
966 Benefit Guaranty Corporation and Trade Adjustment Assistance
967 programs of the Trade Act of 2002 (P.L. 107-210).]

968 (9) "Special health care plan" means a health insurance plan issued
969 by the Health Reinsurance Association established under section 38a-
970 556, as amended by this act, for low-income individuals.

971 (10) "Low-income individual" means an individual whose family
972 income is less than three hundred per cent of the federal poverty level
973 for the calendar year prior to the date of application for an individual
974 special health care plan or the year prior to the anniversary of the
975 effective date of such plan, as certified by such individual.

976 (11) "Reimbursement rate" means, with respect to an individual
977 special health care plan, (A) seventy-five per cent of the
978 reimbursement rate payable under Medicare for benefits normally
979 reimbursable under Medicare, or (B) for services and supplies that are
980 not reimbursed by Medicare, seventy-five per cent of the amount that
981 would be payable under Medicare if Medicare was responsible for
982 payment for such services or supplies, as estimated by the board of
983 directors of the Health Reinsurance Association and approved by the
984 commissioner.

985 Sec. 14. Section 38a-552 of the general statutes is repealed and the
986 following is substituted in lieu thereof (*Effective from passage*):

987 [(a) (1) Every carrier offering individual health insurance in this
988 state shall, as a condition of transacting such health insurance, make an
989 individual comprehensive health care plan, described in section 38a-
990 555, available to every resident of this state except residents who are
991 both sixty-five years of age or older and eligible for Medicare.
992 Individual comprehensive health care plans may be made available
993 through participation in the Health Reinsurance Association in

994 accordance with section 38a-556, or a residual market association, in
995 accordance with section 38a-557. The premium charged for such a plan
996 which is not insured by or through the Health Reinsurance Association
997 or any other residual market association may not exceed the premium
998 which would be applicable through participation in such associations.
999 The premium charged for such a plan insured by or through the
1000 Health Reinsurance Association shall be precisely the premium
1001 established for that particular classification under the Health
1002 Reinsurance Association. (2) Every self-insurer whose plan covers
1003 three or more employees shall make an individual comprehensive
1004 health care plan, described in section 38a-555, available under a
1005 conversion privilege to every person covered by the plan who is a
1006 resident of this state, who is not eligible for Medicare and whose
1007 coverage under the self-insured plan ceases as a result of layoff, death
1008 or termination of employment. The individual comprehensive health
1009 care plans may be provided through a carrier or through participation
1010 in the Health Reinsurance Association in accordance with section 38a-
1011 556. The premium charged for such a plan which is not insured by or
1012 through the Health Reinsurance Association may not exceed the
1013 premium established for that particular classification under the Health
1014 Reinsurance Association. The premium charged for such a plan which
1015 is insured by or through the Health Reinsurance Association shall be
1016 precisely the premium established for that particular classification
1017 under the Health Reinsurance Association.

1018 (b) Every carrier offering group health insurance in this state shall,
1019 as a condition of transacting such health insurance, make a group
1020 comprehensive health care plan, as described in section 38a-554,
1021 available to every resident employer who is not a small employer as
1022 defined in subdivision (4) of section 38a-564.

1023 (c) Except as provided in subdivision (c) of section 38a-505, nothing
1024 in sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, shall
1025 preclude the right of carriers to transact other kinds of insurance for
1026 which they are authorized, nor preclude the right of carriers to transact

1027 any other lawful kind of health insurance.

1028 (d) Nothing in sections 38a-505, 38a-546 and 38a-551 to 38a-559,
1029 inclusive, shall require a carrier to make available coverage under a
1030 group or individual comprehensive health care plan to any person or
1031 group who is already covered under such a plan.]

1032 No individual or organization that provides medical advice,
1033 diagnosis, care or treatment of a type covered under a special health
1034 care plan shall provide such service to any person in this state unless
1035 such individual or organization provides such service, upon request,
1036 on the basis of the applicable reimbursement rate, to low-income
1037 individuals or their dependents covered under such special health care
1038 plans.

1039 Sec. 15. Section 38a-556 of the general statutes is repealed and the
1040 following is substituted in lieu thereof (*Effective from passage*):

1041 (a) There is hereby created a nonprofit legal entity to be known as
1042 the Health Reinsurance Association. All insurers, health care centers
1043 and self-insurers doing business in the state, as a condition to their
1044 authority to transact the applicable kinds of health insurance defined
1045 in section 38a-551, as amended by this act, shall be members of the
1046 association. The association shall perform its functions under a plan of
1047 operation established and approved under subsection [(a)] (b) of this
1048 section, and shall exercise its powers through a board of directors
1049 established under this section.

1050 [(a)] (b) (1) The board of directors of the association shall be made
1051 up of nine individuals selected by participating members, subject to
1052 approval by the commissioner, two of whom shall be appointed by the
1053 commissioner on or before July 1, 1993, to represent health care
1054 centers. To select the initial board of directors, and to initially organize
1055 the association, the commissioner shall give notice to all members of
1056 the time and place of the organizational meeting. In determining
1057 voting rights at the organizational meeting each member shall be

1058 entitled to vote in person or proxy. The vote shall be a weighted vote
1059 based upon the net health insurance premium derived from this state
1060 in the previous calendar year. If the board of directors is not selected
1061 within sixty days after notice of the organizational meeting, the
1062 commissioner may appoint the initial board. In approving or selecting
1063 members of the board, the commissioner may consider, among other
1064 things, whether all members are fairly represented. Members of the
1065 board may be reimbursed from the moneys of the association for
1066 expenses incurred by them as members, but shall not otherwise be
1067 compensated by the association for their services.

1068 (2) The board shall submit to the commissioner a plan of operation
1069 for the association necessary or suitable to assure the fair, reasonable
1070 and equitable administration of the association. The plan of operation
1071 shall become effective upon approval in writing by the commissioner.
1072 [consistent with the date on which the coverage under sections 38a-
1073 505, 38a-546 and 38a-551 to 38a-559, inclusive, must be made available.
1074 The commissioner shall, after notice and hearing, approve the plan of
1075 operation provided such plan is determined to be suitable to assure the
1076 fair, reasonable and equitable administration of the association, and
1077 provides for the sharing of association gains or losses on an equitable
1078 proportionate basis. If the board fails to submit a suitable plan of
1079 operation within one hundred eighty days after its appointment, or if
1080 at any time thereafter the board fails to submit suitable amendments to
1081 the plan, the commissioner shall, after notice and hearing, adopt and
1082 promulgate such reasonable rules as are necessary or advisable to
1083 effectuate the provisions of this section. Such rules] Such plan shall
1084 continue in force until modified by the commissioner or superseded by
1085 a plan submitted by the board and approved by the commissioner. The
1086 plan of operation shall; [in addition to requirements enumerated in
1087 sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive:] (A)
1088 Establish procedures for the handling and accounting of assets and
1089 moneys of the association; (B) establish regular times and places for
1090 meetings of the board of directors; (C) establish procedures for records

1091 to be kept of all financial transactions, and for the annual fiscal
1092 reporting to the commissioner; (D) establish procedures whereby
1093 selections for the board of directors shall be made and submitted to the
1094 commissioner; (E) establish procedures to amend, subject to the
1095 approval of the commissioner, the plan of operations; (F) establish
1096 procedures for the selection of an administrator and set forth the
1097 powers and duties of the administrator; (G) contain additional
1098 provisions necessary or proper for the execution of the powers and
1099 duties of the association; and (H) [establish procedures for the
1100 advertisement on behalf of all participating carriers of the general
1101 availability of the comprehensive coverage under sections 38a-505,
1102 38a-546 and 38a-551 to 38a-559, inclusive; (I) contain additional
1103 provisions necessary for the association to qualify as an acceptable
1104 alternative mechanism in accordance with Section 2744 of the Public
1105 Health Service Act, as set forth in the Health Insurance Portability and
1106 Accountability Act of 1996, P.L. 104-191; and (J)] contain additional
1107 provisions necessary for the association to establish health insurance
1108 plans that qualify as acceptable coverage in accordance with the
1109 Pension Benefit Guaranty Corporation and [Trade Adjustment
1110 Assistance programs of the Trade Act of 2002, P.L. 107-210. The
1111 commissioner may adopt regulations, in accordance with the
1112 provisions of chapter 54, to establish criteria for the association to
1113 qualify as an acceptable alternative mechanism] other state or federal
1114 programs that may be established.

1115 [(b)] (c) The association shall have the general powers and authority
1116 granted under the laws of this state to carriers to transact the kinds of
1117 insurance defined under section 38a-551, as amended by this act, and
1118 in addition thereto, the specific authority to: (1) Enter into contracts
1119 necessary or proper to carry out the provisions and purposes of this
1120 section and sections [38a-505, 38a-546 and] 38a-551, as amended by this
1121 act, and 38a-556a to 38a-559, inclusive; (2) sue or be sued, including
1122 taking any legal actions necessary or proper for recovery of any
1123 assessments for, on behalf of, or against participating members; (3)

1124 take such legal action as necessary to avoid the payment of improper
1125 claims against the association or the coverage provided by or through
1126 the association; (4) establish, with respect to health insurance provided
1127 by or on behalf of the association, appropriate rates, scales of rates, rate
1128 classifications and rating adjustments, such rates not to be
1129 unreasonable in relation to the coverage provided and the operational
1130 expenses of the association; (5) administer any type of reinsurance
1131 program, for or on behalf of participating members; (6) pool risks
1132 among participating members; (7) issue policies of insurance [on an
1133 indemnity or provision of service basis providing the coverage]
1134 required or permitted by this section and sections [38a-505, 38a-546
1135 and] 38a-551, as amended by this act, and 38a-556a to 38a-559,
1136 inclusive, in its own name or on behalf of participating members; (8)
1137 administer separate pools, separate accounts or other plans as deemed
1138 appropriate for separate members or groups of members; (9) operate
1139 and administer any combination of plans, pools, reinsurance
1140 arrangements or other mechanisms as deemed appropriate to best
1141 accomplish the fair and equitable operation of the association; (10) set
1142 limits on the amounts of reinsurance that may be ceded to the
1143 association by its members; (11) appoint from among participating
1144 members appropriate legal, actuarial and other committees as
1145 necessary to provide technical assistance in the operation of the
1146 association, policy and other contract design, and any other function
1147 within the authority of the association; [and] (12) apply for and accept
1148 grants, gifts and bequests of funds from other states, federal and
1149 interstate agencies and independent authorities, private firms,
1150 individuals and foundations for the purpose of carrying out its
1151 responsibilities. Any such funds received shall be deposited in the
1152 General Fund and shall be credited to a separate nonlapsing account
1153 within the General Fund for the Health Reinsurance Association and
1154 may be used by the Health Reinsurance Association in the
1155 performance of its duties; and (13) perform such other duties and
1156 responsibilities as may be required by state or federal law or permitted
1157 by state or federal law and approved by the commissioner.

1158 [(c) Every member shall participate in the association in accordance
1159 with the provisions of this subsection. (1) A participating member shall
1160 determine the particular risks it elects to have written by or through
1161 the association. A member shall designate which of the following
1162 classes of risks it shall underwrite in the state, from which classes of
1163 risk it may elect to reinsure selected risks: (A) Individual, excluding
1164 group conversion; and (B) individual, including group conversion. (2)
1165 No member shall be permitted to select out individual lives from an
1166 employer group to be insured by or through the association. Members
1167 electing to administer risks that are insured by or through the
1168 association shall comply with the benefit determination guidelines and
1169 the accounting procedures established by the association. A risk
1170 insured by or through the association cannot be withdrawn by the
1171 participating member except in accordance with the rules established
1172 by the association. (3)]

1173 (d) Rates for coverage issued by or through the association shall not
1174 be excessive, inadequate or unfairly discriminatory. [Separate scales of
1175 premium rates based on age shall apply, but rates shall not be adjusted
1176 for area variations in provider costs. Premium rates shall take into
1177 consideration the substantial extra morbidity and administrative
1178 expenses for association risks, reimbursement or reasonable expenses
1179 incurred for the writing of association risks and the level of rates
1180 charged by insurers for groups of ten lives, provided incurred losses
1181 that result from provision of coverage in accordance with section 38a-
1182 537 shall not be considered. In no event shall the rate for a given
1183 classification or group be less than one hundred twenty-five per cent
1184 or more than one hundred fifty per cent of the average rate charged for
1185 that classification with similar characteristics under a policy covering
1186 ten lives.] All rates shall be promulgated by the association through an
1187 actuarial committee consisting of five persons who are members of the
1188 American Academy of Actuaries, shall be filed with the commissioner
1189 and may be disapproved within sixty days [from] after the filing
1190 thereof if excessive, inadequate or unfairly discriminatory.

1191 [(d)] (e) (1) Following the close of each fiscal year, the administrator
1192 shall determine the net premiums, reinsurance premiums less
1193 administrative expense allowance, the expense of administration
1194 pertaining to the reinsurance operations of the association and the
1195 incurred losses for the year. Any net loss shall be assessed to all
1196 participating members in proportion to their respective shares of the
1197 total health insurance premiums earned in this state during the
1198 calendar year, or with paid losses in the year, coinciding with or
1199 ending during the fiscal year of the association or on any other
1200 equitable basis as may be provided in the plan of operations. For self-
1201 insured members of the association, health insurance premiums
1202 earned shall be established by dividing the amount of paid health
1203 losses for the applicable period by eighty-five per cent. Net gains, if
1204 any, shall be held at interest to offset future losses or allocated to
1205 reduce future premiums.

1206 (2) Any net loss to the association represented by the excess of its
1207 actual expenses of administering policies issued by the association
1208 over the applicable expense allowance shall be separately assessed to
1209 those participating members who do not elect to administer their
1210 plans. All assessments shall be on an equitable formula established by
1211 the board.

1212 (3) The association shall conduct periodic audits to assure the
1213 general accuracy of the financial data submitted to the association and
1214 the association shall have an annual audit of its operations by an
1215 independent certified public accountant. The annual audit shall be
1216 filed with the commissioner for his review and the association shall be
1217 subject to the provisions of section 38a-14.

1218 [(4) For the fiscal year ending December 31, 1993, and the first
1219 quarter of the fiscal year ending December 31, 1994, the administrator
1220 shall not include health care centers in assessing any net losses to
1221 participating members.]

1222 [(e)] (f) All policy forms issued by or through the association shall
1223 conform in substance to prototype forms developed by the association,
1224 shall in all other respects conform to the requirements of this section
1225 and sections [38a-505, 38a-546 and] 38a-551, as amended by this act,
1226 and 38a-556a to 38a-559, inclusive, and shall be approved by the
1227 commissioner. The commissioner may disapprove any such form if it
1228 contains a provision or provisions [which] that are unfair or deceptive
1229 or [which] that encourage misrepresentation of the policy.

1230 [(f)] (g) Unless otherwise permitted by the plan of operation, the
1231 association shall not issue, reissue or continue in force
1232 [comprehensive] health care plan coverage with respect to any person
1233 who is already covered under an individual or group [comprehensive]
1234 health care plan, or who is sixty-five years of age or older and eligible
1235 for Medicare or who is not a resident of this state. [Coverage provided
1236 to a HIPAA or health care tax credit eligible individual may be
1237 terminated to the extent permitted by HIPAA or the Trade Act of 2002,
1238 respectively.]

1239 [(g)] (h) Benefits payable under a [comprehensive] health care plan
1240 insured by or reinsured through the association shall be paid net of all
1241 other health insurance benefits paid or payable through any other
1242 source, and net of all health insurance coverages provided by or
1243 pursuant to any other state or federal law including Title XVIII of the
1244 Social Security Act, Medicare, but excluding Medicaid.

1245 [(h)] (i) There shall be no liability on the part of and no cause of
1246 action of any nature shall arise against any carrier or its agents or its
1247 employees, the Health Reinsurance Association or its agents or its
1248 employees or the residual market mechanism established under the
1249 provisions of section 38a-557, as amended by this act, or its agents or
1250 its employees, or the commissioner or [his] the commissioner's
1251 representatives for any action taken by them in the performance of
1252 their duties under this section and sections [38a-505, 38a-546 and] 38a-
1253 551, as amended by this act, and 38a-556a to 38a-559, inclusive. This

1254 provision shall not apply to the obligations of a carrier, a self-insurer,
1255 the Health Reinsurance Association or the residual market mechanism
1256 for payment of benefits provided under a [comprehensive] health care
1257 plan.

1258 Sec. 16. Section 38a-557 of the general statutes is repealed and the
1259 following is substituted in lieu thereof (*Effective from passage*):

1260 (a) Hospital service corporations and medical service corporations
1261 may [elect to meet the obligations of section 38a-552 by participating]
1262 participate in the Health Reinsurance Association established in
1263 section 38a-556, as amended by this act, as a full member thereof, or by
1264 making [comprehensive] health care plans available directly through a
1265 subscriber contract or combination of contracts or by forming a
1266 separate residual market mechanism substantially similar to [the
1267 association established in section 38a-556] said association.

1268 (b) In the event that hospital service corporations and medical
1269 service corporations choose to form a separate residual market
1270 mechanism, the commissioner shall have the same regulatory powers
1271 over that residual market mechanism as the commissioner has over the
1272 Health Reinsurance Association, and such residual market mechanism
1273 shall have the same powers and duties as the association. Rating
1274 classifications under a residual market mechanism established under
1275 this section need not be the same as classifications established under
1276 the association, but any rates established by the residual market
1277 mechanism shall be approved by the commissioner. The commissioner
1278 shall [promulgate] adopt regulations, in accordance with the
1279 provisions of chapter 54, to carry out the requirements of this section.

1280 (c) If hospital service corporations and medical service corporations
1281 do not elect to participate in the Health Reinsurance Association, such
1282 service corporations shall be required to make an individual
1283 [comprehensive] health care plan available to every resident of this
1284 state except residents who are both sixty-five years of age or older and

1285 eligible for Medicare and whose coverage under a group or individual
1286 contract issued by such service corporations has terminated. Such
1287 coverage may be made available through a separate residual market
1288 mechanism established under this section.

1289 Sec. 17. Section 38a-564 of the general statutes is repealed and the
1290 following is substituted in lieu thereof (*Effective from passage*):

1291 As used in this section and sections [12-201, 12-211, 12-212a and 38a-
1292 565 to 38a-572, inclusive] 38a-566, as amended by this act, 38a-567, as
1293 amended by this act, 38a-569, as amended by this act, and 38a-574, as
1294 amended by this act:

1295 (1) "Pool" means the Connecticut Small Employer Health
1296 Reinsurance Pool, established under section 38a-569, as amended by
1297 this act.

1298 (2) "Board" means the board of directors of the pool.

1299 [(3) "Eligible employee" means an employee who works a normal
1300 work week of twenty or more hours and includes a sole proprietor, a
1301 partner of a partnership or an independent contractor, provided such
1302 sole proprietor, partner or contractor is included as an employee under
1303 a health care plan of a small employer but does not include an
1304 employee who works on a seasonal, temporary or substitute basis.
1305 "Eligible employee" shall include any employee who is not actively at
1306 work but is covered under the small employer's health insurance plan
1307 pursuant to (A) workers' compensation, (B) continuation of benefits
1308 pursuant to section 38a-554, or (C) other applicable laws.

1309 (4) (A) "Small employer" means any person, firm, corporation,
1310 limited liability company, partnership or association actively engaged
1311 in business or self-employed for at least three consecutive months
1312 who, on at least fifty per cent of its working days during the preceding
1313 twelve months, employed no more than fifty eligible employees, the
1314 majority of whom were employed within the state of Connecticut.

1315 "Small employer" includes a self-employed individual. For the
1316 purposes of determining the number of eligible employees under this
1317 subdivision: (i) Companies that are affiliated companies, as defined in
1318 section 33-840, or that are eligible to file a combined tax return for
1319 purposes of taxation under chapter 208 shall be considered one
1320 employer; (ii) employees covered through the employer by health
1321 insurance plans or insurance arrangements issued to or in accordance
1322 with a trust established pursuant to collective bargaining subject to the
1323 federal Labor Management Relations Act shall not be counted; (iii)
1324 employees who are not actively at work but are covered under the
1325 small employer's health insurance plan pursuant to workers'
1326 compensation, continuation of benefits pursuant to section 38a-554 or
1327 other applicable laws shall not be counted; and (iv) employees who
1328 work a normal work week of less than thirty hours shall not be
1329 counted. Except as otherwise specifically provided, provisions of this
1330 section and sections 12-201, 12-211, 12-212a and 38a-565 to 38a-572,
1331 inclusive, that apply to a small employer shall continue to apply until
1332 the plan anniversary following the date the employer no longer meets
1333 the requirements of this definition.

1334 (B) "Small employer" does not include (i) a municipality procuring
1335 health insurance pursuant to section 5-259, (ii) a private school in this
1336 state procuring health insurance through a health insurance plan or an
1337 insurance arrangement sponsored by an association of such private
1338 schools, (iii) a nonprofit organization procuring health insurance
1339 pursuant to section 5-259, unless the Secretary of the Office of Policy
1340 and Management and the State Comptroller make a request in writing
1341 to the Insurance Commissioner that such nonprofit organization be
1342 deemed a small employer for the purposes of this chapter, (iv) an
1343 association for personal care assistants procuring health insurance
1344 pursuant to section 5-259, or (v) a community action agency procuring
1345 health insurance pursuant to section 5-259.]

1346 (3) "Employee" means an individual employed by an employer.
1347 "Employee" does not include (A) an individual and such individual's

1348 spouse with respect to an incorporated or unincorporated trade or
1349 business that is wholly owned by such individual, by such individual's
1350 spouse or by such individual and such individual's spouse, or (B) a
1351 partner in a partnership and such partner's spouse with respect to such
1352 partnership.

1353 (4) (A) "Small employer" means an employer that, (i) prior to
1354 January 1, 2016, employed an average of at least one but not more than
1355 fifty employees on business days during the preceding calendar year
1356 and employs at least one employee on the first day of the group health
1357 insurance plan year, and (ii) on and after January 1, 2016, employed an
1358 average of at least one but not more than one hundred employees on
1359 business days during the preceding calendar year and employs at least
1360 one employee on the first day of the group health insurance plan year.
1361 "Small employer" does not include a sole proprietorship that employs
1362 only the sole proprietor or the spouse of such sole proprietor.

1363 (B) (i) For purposes of subparagraph (A) of this subdivision, the
1364 number of employees shall be determined by adding (I) the number of
1365 full-time employees for each month who work a normal work week of
1366 thirty hours or more, and (II) the number of full-time equivalent
1367 employees, calculated for each month by dividing by one hundred
1368 twenty the aggregate number of hours worked for such month by
1369 employees who work a normal work week of less than thirty hours,
1370 and averaging such total for the calendar year.

1371 (ii) If an employer was not in existence throughout the preceding
1372 calendar year, the number of employees shall be based on the average
1373 number of employees that such employer reasonably expects to
1374 employ in the current calendar year.

1375 (C) All persons treated as a single employer under Section 414 of the
1376 Internal Revenue Code of 1986, or any subsequent corresponding
1377 internal revenue code of the United States, as amended from time to
1378 time, shall be considered a single employer for purposes of this

1379 subdivision.

1380 (5) "Insurer" means any insurance company, hospital [or] service
1381 corporation, medical service corporation [,] or health care center,
1382 authorized to transact health insurance business in this state.

1383 (6) "Insurance arrangement" means any multiple employer welfare
1384 arrangement, as defined in Section 3 of the Employee Retirement
1385 Income Security Act of 1974, as amended from time to time, except for
1386 any such arrangement that is fully insured within the meaning of
1387 Section 514(b)(6) of said act, as amended from time to time.

1388 (7) "Health insurance plan" means any hospital and medical expense
1389 incurred policy, hospital or medical service plan contract and health
1390 care center subscriber contract. [and] "Health insurance plan" does not
1391 include (A) accident only, credit, dental, vision, Medicare supplement,
1392 long-term care or disability insurance, hospital indemnity coverage,
1393 coverage issued as a supplement to liability insurance, insurance
1394 arising out of a workers' compensation or similar law, automobile
1395 medical-payments insurance, or insurance under which beneficiaries
1396 are payable without regard to fault and which is statutorily required to
1397 be contained in any liability insurance policy or equivalent self-
1398 insurance, or (B) policies of specified disease or limited benefit health
1399 insurance, provided that the carrier offering such policies files on or
1400 before March first of each year a certification with the commissioner
1401 that contains the following: (i) A statement from the carrier certifying
1402 that such policies are being offered and marketed as supplemental
1403 health insurance and not as a substitute for hospital or medical
1404 expense insurance; (ii) a summary description of each such policy
1405 including the average annual premium rates, or range of premium
1406 rates in cases where premiums vary by age, gender or other factors,
1407 charged for such policies in the state; and (iii) in the case of a policy
1408 that is described in this subparagraph and that is offered for the first
1409 time in this state on or after October 1, 1993, the carrier files with the
1410 commissioner the information and statement required in this

1411 subparagraph at least thirty days prior to the date such policy is issued
1412 or delivered in this state.

1413 (8) "Plan of operation" means the plan of operation of the pool,
1414 including articles, bylaws and operating rules, adopted by the board
1415 pursuant to section 38a-569, as amended by this act.

1416 [(9) "Late enrollee" means an eligible employee or dependent who
1417 requests enrollment in a small employer's health insurance plan
1418 following the initial enrollment period provided under the terms of the
1419 first plan for which such employee or dependent was eligible through
1420 such small employer, provided an eligible employee or dependent
1421 shall not be considered a late enrollee if (A) the request for enrollment
1422 is made within thirty days after termination of coverage provided
1423 under another group health insurance plan and if the individual had
1424 not initially requested coverage under such plan solely because he was
1425 covered under another group health insurance plan and coverage
1426 under that plan has ceased due to termination of employment, death of
1427 a spouse, or divorce, or due to that plan's involuntary termination or
1428 cancellation by its carrier for reasons other than nonpayment of
1429 premium, or (B) the individual is employed by an employer who offers
1430 multiple health insurance plans and the individual elects a different
1431 health insurance plan during an open enrollment period, or (C) a court
1432 has ordered coverage be provided for a spouse or minor child under a
1433 covered employee's plan and request for enrollment is made within
1434 thirty days after issuance of such court order, or (D) if the request for
1435 enrollment is made within thirty days after the marriage of such
1436 employee or the birth or adoption of the first child by such employee
1437 after the later of the commencement of the employer's plan or the date
1438 the pool becomes operational, and satisfactory evidence of such
1439 marriage, birth or adoption is provided to the small employer carrier.

1440 (10) "Department" means the Insurance Department.

1441 (11) "Special health care plan" means a health insurance plan for

1442 previously uninsured small employers, established by the board in
1443 accordance with section 38a-565 or by the Health Reinsurance
1444 Association in accordance with section 38a-570.

1445 (12) "Small employer health care plan" means a health insurance
1446 plan for small employers, established by the board in accordance with
1447 section 38a-568.]

1448 [(13)] (9) "Dependent" means the spouse or child of an eligible
1449 employee, subject to applicable terms of the health insurance plan
1450 covering such employee. "Dependent" [shall also include] includes any
1451 dependent [that] who is covered under the small employer's health
1452 insurance plan pursuant to workers' compensation, continuation of
1453 benefits pursuant to section [38a-554] 38a-512a, as amended by this act,
1454 or other applicable laws.

1455 [(14)] (10) "Commissioner" means the Insurance Commissioner.

1456 [(15)] (11) "Member" means each insurer and insurance arrangement
1457 participating in the pool.

1458 [(16)] (12) "Small employer carrier" means any insurer or insurance
1459 arrangement [which] that offers or maintains group health insurance
1460 plans covering eligible employees of one or more small employers.

1461 [(17)] "Preexisting conditions provision" means a policy provision
1462 that excludes coverage for charges or expenses incurred during a
1463 specified period following the insured's effective date of coverage as to
1464 a condition that, during a specified period immediately preceding the
1465 effective date of coverage, had manifested itself in such a manner as
1466 would cause an ordinary prudent person to seek diagnosis, care or
1467 treatment or for which medical advice, diagnosis, care or treatment
1468 was recommended or received as to that condition.

1469 (18) "Base premium rate" means, as to any health insurance plan or
1470 insurance arrangement covering one or more employees of a small

1471 employer, the lowest new business premium rate charged by the
1472 insurer or insurance arrangement for the same or similar coverage
1473 which is equivalent in value under a plan or arrangement covering any
1474 small employer with similar case characteristics, other than claim
1475 experience, as determined by such insurer or insurance arrangement,
1476 except that as to any small employer carrier or insurance arrangement
1477 not issuing new health insurance plans or insurance arrangements to a
1478 small employer, "base premium rate" means the lowest rate charged a
1479 small employer for the same or similar coverage which is equivalent in
1480 value, under a plan or arrangement covering any small employer with
1481 similar case characteristics, other than claim experience, as determined
1482 by such insurer or insurance arrangement.

1483 (19) "Low-income eligible employee" means an eligible employee of
1484 a small employer whose annualized wages from such small employer
1485 determined as of the effective date of the special health care plan or as
1486 of any anniversary of such effective date as certified to the insurer or
1487 insurance arrangement or the Health Reinsurance Association, as the
1488 case may be, by such small employer is less than three hundred per
1489 cent of the federal poverty level applicable to such person.

1490 (20) "Medicare" means the Health Insurance for the Aged Act, Title
1491 XVIII of the Social Security Amendments of 1965, as amended from
1492 time to time.

1493 (21) "Health Reinsurance Association" means the entity established
1494 and maintained in accordance with the provisions of sections 38a-505,
1495 38a-546 and 38a-551 to 38a-559, inclusive.

1496 (22) "Reimbursement rate" means, as to individuals covered under
1497 special health care plans or an individual special health care plan,
1498 seventy-five per cent of the Medicare reimbursement rate for benefits
1499 normally reimbursable under Medicare. For services or supplies not
1500 reimbursed by Medicare, such reimbursement shall be seventy-five per
1501 cent of the amount which would be payable under Medicare, if

1502 Medicare was responsible for benefit payments under such plans for
1503 such services and supplies, as determined by the board and approved
1504 by the commissioner.

1505 (23) "Individual special health care plan" means a health insurance
1506 plan for individuals, issued by the Health Reinsurance Association in
1507 accordance with section 38a-571 or issued by an insurer in accordance
1508 with section 38a-565.

1509 (24) "Low-income individual" means an individual whose adjusted
1510 gross income (AGI) for the individual and spouse, from the most
1511 recent federal tax return filed prior to the date of application for the
1512 individual special health care plan or prior to any anniversary of the
1513 effective date of the plan, as certified by such individual, is less than
1514 three hundred per cent of the applicable federal poverty level.

1515 (25) "Medicare reimbursement rate" means the amount which
1516 would be payable under Medicare for benefits normally reimbursed
1517 under Medicare.]

1518 [(26)] (13) "Health care center" [means health care center as defined]
1519 has the same meaning as provided in section 38a-175.

1520 [(27)] (14) "Case characteristics" means demographic or other
1521 objective characteristics of a small employer, including age [, sex,
1522 family composition, location, size of group, administrative cost savings
1523 resulting from the administration of an association group plan or a
1524 plan written pursuant to section 5-259 and industry classification, as
1525 determined by a small employer carrier, that are considered by the
1526 small employer carrier in the determination of premium rates for the
1527 small employer. Claim] and geographic location. "Case characteristics"
1528 does not include claims experience, health status [, and] or duration of
1529 coverage since issue. [are not case characteristics for the purpose of
1530 sections 38a-564 to 38a-572, inclusive.]

1531 [(28) "Actuarial certification" means a written statement by a

1532 member of the American Academy of Actuaries or other individual
1533 acceptable to the commissioner that a small employer carrier is in
1534 compliance with the provisions of subdivisions (4), (6), (7) and (9) of
1535 section 38a-567 and the regulations promulgated by the commissioner
1536 pursuant to section 38a-567, based upon the person's examination,
1537 including a review of the appropriate records and of the actuarial
1538 assumptions and methods used by the small employer carrier in
1539 establishing premium rates for applicable health benefit plans.]

1540 Sec. 18. Section 38a-566 of the general statutes is repealed and the
1541 following is substituted in lieu thereof (*Effective from passage*):

1542 (a) Any individual or group health insurance plan or any insurance
1543 arrangement shall be subject to the provisions of sections [12-201, 12-
1544 211, 12-212a and 38a-564 to 38a-572, inclusive] 38a-552, as amended by
1545 this act, 38a-564, as amended by this act, 38a-567, as amended by this
1546 act, and 38a-569, as amended by this act, if it provides health insurance
1547 or is an insurance arrangement covering one or more employees of a
1548 small employer and if any one of the following conditions are met:

1549 (1) Any portion of the premium or benefits is paid by a small
1550 employer or any covered individual is reimbursed, whether through
1551 wage adjustments or otherwise, by a small employer for any portion of
1552 the premium; or

1553 (2) The health insurance plan or arrangement is treated by the
1554 employer or any of the covered individuals as part of a plan or
1555 program for the purposes of Section 162 or Section 106 of the United
1556 States Internal Revenue Code.

1557 (b) Nothing in this section shall be construed to apply the provisions
1558 of sections 12-202 and 12-212a, as amended by this act, to health care
1559 centers.

1560 (c) Notwithstanding the provisions of subsection (a) of this section,
1561 health insurance plans or insurance arrangements issued to or in

1562 accordance with a trust established pursuant to collective bargaining,
1563 subject to the federal Labor Management Relations Act and which
1564 cover, in the aggregate, more than twenty-five employees of all
1565 participating employers, shall not be subject to the provisions of
1566 section 38a-567, as amended by this act, or subparagraph (A) of
1567 subdivision (2) of subsection [(e)] (c) of section 38a-569, as amended by
1568 this act. [and insurers or insurance arrangements issuing only such
1569 plans shall not be considered small employer carriers for purposes of
1570 sections 38a-565 and 38a-568.]

1571 (d) A small employer carrier that ceases marketing to small
1572 employers [as provided in subsection (d) of section 38a-568] shall not
1573 cease enrolling new employers in a policy issued to provide coverage
1574 to the members of a trade association or to a trust on behalf of a trade
1575 association if the following conditions exist:

1576 (1) Such trade association is a not-for-profit trade association
1577 qualified under 26 USC Section 501c(6), was not formed solely for the
1578 purpose of providing insurance and has been operating continuously
1579 for at least twenty-five years; [.]

1580 (2) The policy issued to or on behalf of such association was in
1581 existence prior to June 1, 1990, and has annual premiums of less than
1582 twenty-five million dollars; [.]

1583 (3) Such policy is offered on a guaranteed issue basis to all small
1584 employer members and only to members of such trade association.

1585 [(e) Subsection (a) of this section shall not apply to an individual
1586 health insurance plan issued to a self-employed individual if the
1587 carrier discloses on the application and marketing materials, in not less
1588 than ten-point type, the following notice: "THIS PLAN IS ISSUED ON
1589 AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL
1590 HEALTH INSURANCE PLAN."]

1591 Sec. 19. Section 38a-567 of the general statutes is repealed and the

1592 following is substituted in lieu thereof (*Effective from passage*):

1593 Health insurance plans, associations of small employers and other
1594 insurance arrangements covering small employers and insurers and
1595 producers marketing such plans and arrangements shall be subject to
1596 the following provisions:

1597 [(1) (A) (i) Any such insurer or producer marketing such plans or
1598 arrangements shall offer premium quotes to small employers upon
1599 request for coverage for employees who work a normal work week of
1600 thirty or more hours. Upon request by a small employer, such insurer
1601 or producer shall offer premium quotes for coverage for employees
1602 that include those who work a normal work week of at least twenty
1603 hours.

1604 (ii) No small employer that has requested premium quotes for
1605 coverage for employees that include those who work a normal work
1606 week of less than thirty hours shall be required to accept such quotes
1607 or coverage in lieu of premium quotes or coverage for only those
1608 employees who work a normal work week of thirty or more hours.

1609 (iii) Nothing in this subparagraph shall require a small employer
1610 that offers coverage to its employees who work a normal work week of
1611 thirty hours or more to offer coverage to its employees who work a
1612 normal work week of less than thirty hours.]

1613 (1) (A) Any such plan or arrangement shall be offered on a
1614 guaranteed issue basis with respect to all eligible employees or
1615 dependents of such employees, at the option of the small employer,
1616 policyholder or contractholder, as the case may be.

1617 (B) Any such plan or arrangement shall be renewable with respect
1618 to all eligible employees or dependents at the option of the small
1619 employer, policyholder or contractholder, as the case may be, except:
1620 (i) For nonpayment of the required premiums by the small employer,
1621 policyholder or contractholder; (ii) for fraud or misrepresentation of

1622 the small employer, policyholder or contractholder or, with respect to
1623 coverage of individual insured, the insureds or their representatives;
1624 (iii) for noncompliance with plan or arrangement provisions; (iv) when
1625 the number of insureds covered under the plan or arrangement is less
1626 than the number of insureds or percentage of insureds required by
1627 participation requirements under the plan or arrangement; or (v) when
1628 the small employer, policyholder or contractholder is no longer
1629 actively engaged in the business in which it was engaged on the
1630 effective date of the plan or arrangement.

1631 (C) Renewability of coverage may be effected by either continuing
1632 in effect a plan or arrangement covering a small employer or by
1633 substituting upon renewal for the prior plan or arrangement the plan
1634 or arrangement then offered by the carrier that most closely
1635 corresponds to the prior plan or arrangement and is available to other
1636 small employers. Such substitution shall only be made under
1637 conditions approved by the commissioner. A carrier may substitute a
1638 plan or arrangement as [stated above] set forth in this subparagraph
1639 only if the carrier effects the same substitution upon renewal for all
1640 small employers previously covered under the particular plan or
1641 arrangement, unless otherwise approved by the commissioner. The
1642 substitute plan or arrangement shall be subject to the rating restrictions
1643 specified in this section on the same basis as if no substitution had
1644 occurred, except for an adjustment based on coverage differences.

1645 [(D) Notwithstanding the provisions of this subdivision, any such
1646 plan or arrangement, or any coverage provided under such plan or
1647 arrangement may be rescinded for fraud, intentional material
1648 misrepresentation or concealment by an applicant, employee,
1649 dependent or small employer.

1650 (E) Any individual who was not a late enrollee at the time of his or
1651 her enrollment and whose coverage is subsequently rescinded shall be
1652 allowed to reenroll as of a current date in such plan or arrangement
1653 subject to any preexisting condition or other provisions applicable to

1654 new enrollees without previous coverage. On and after the effective
1655 date of such individual's reenrollment, the small employer carrier may
1656 modify the premium rates charged to the small employer for the
1657 balance of the current rating period and for future rating periods, to
1658 the level determined by the carrier as applicable under the carrier's
1659 established rating practices had full, accurate and timely underwriting
1660 information been supplied when such individual initially enrolled in
1661 the plan. The increase in premium rates allowed by this provision for
1662 the balance of the current rating period shall not exceed twenty-five
1663 per cent of the small employer's current premium rates. Any such
1664 increase for the balance of said current rating period shall not be
1665 subject to the rate limitation specified in subdivision (6) of this section.
1666 The rate limitation specified in this section shall otherwise be fully
1667 applicable for the current and future rating periods. The modification
1668 of premium rates allowed by this subdivision shall cease to be
1669 permitted for all plans and arrangements on the first rating period
1670 commencing on or after July 1, 1995.

1671 (2) Except in the case of a late enrollee who has failed to provide
1672 evidence of insurability satisfactory to the insurer, the plan or
1673 arrangement may not exclude any eligible employee or dependent
1674 who would otherwise be covered under such plan or arrangement on
1675 the basis of an actual or expected health condition of such person. No
1676 plan or arrangement may exclude an eligible employee or eligible
1677 dependent who, on the day prior to the initial effective date of the plan
1678 or arrangement, was covered under the small employer's prior health
1679 insurance plan or arrangement pursuant to workers' compensation,
1680 continuation of benefits pursuant to section 38a-554 or other applicable
1681 laws. The employee or dependent shall request coverage under the
1682 new plan or arrangement on a timely basis and such coverage shall
1683 terminate in accordance with the provisions of the applicable law.

1684 (3) (A) For rating periods commencing on or after October 1, 1993,
1685 and prior to July 1, 1994, the premium rates charged or offered for a
1686 rating period for all plans and arrangements may not exceed one

1687 hundred thirty-five per cent of the base premium rate for all plans or
1688 arrangements.

1689 (B) For rating periods commencing on or after July 1, 1994, and prior
1690 to July 1, 1995, the premium rates charged or offered for a rating
1691 period for all plans or arrangements may not exceed one hundred
1692 twenty per cent of the base premium rate for such rating period. The
1693 provisions of this subdivision shall not apply to any small employer
1694 who employs more than twenty-five eligible employees.

1695 (4) For rating periods commencing on or after October 1, 1993, and
1696 prior to July 1, 1995, the percentage increase in the premium rate
1697 charged to a small employer, who employs not more than twenty-five
1698 eligible employees, for a new rating period may not exceed the sum of:

1699 (A) The percentage change in the base premium rate measured from
1700 the first day of the prior rating period to the first day of the new rating
1701 period;

1702 (B) An adjustment of the small employer's premium rates for the
1703 prior rating period, and adjusted pro rata for rating periods of less
1704 than one year, due to the claim experience, health status or duration of
1705 coverage of the employees or dependents of the small employer, such
1706 adjustment (i) not to exceed ten per cent annually for the rating
1707 periods commencing on or after October 1, 1993, and prior to July 1,
1708 1994, and (ii) not to exceed five per cent annually for the rating periods
1709 commencing on or after July 1, 1994, and prior to July 1, 1995; and

1710 (C) Any adjustments due to change in coverage or change in the
1711 case characteristics of the small employer, as determined from the
1712 small employer carrier's applicable rate manual.]

1713 (D) Any such plan or arrangement shall provide special enrollment
1714 periods (i) to all eligible employees or dependents as set forth in 45
1715 CFR 147.104, as amended from time to time, and (ii) for coverage
1716 under such plan or arrangement ordered by a court for a spouse or

1717 minor child of an eligible employee where request for enrollment is
1718 made not later than thirty days after the issuance of such court order.

1719 [(5) (A)] (2) (A) As used in this subdivision, "grandfathered plan"
1720 has the same meaning as "grandfathered health plan" as provided in
1721 the Patient Protection and Affordable Care Act, P.L. 111-148, as
1722 amended from time to time.

1723 (B) With respect to grandfathered plans [or arrangements issued on
1724 or after July 1, 1995] issued to small employers, the premium rates
1725 charged or offered [to small employers] shall be established on the
1726 basis of a [community rate] single pool of all grandfathered plans,
1727 adjusted to reflect one or more of the following classifications:

1728 (i) Age, provided age brackets of less than five years shall not be
1729 utilized;

1730 (ii) Gender;

1731 (iii) Geographic area, provided an area smaller than a county shall
1732 not be utilized;

1733 (iv) Industry, provided the rate factor associated with any industry
1734 classification shall not vary from the arithmetic average of the highest
1735 and lowest rate factors associated with all industry classifications by
1736 greater than fifteen per cent of such average, and provided further, the
1737 rate factors associated with any industry shall not be increased by
1738 more than five per cent per year;

1739 (v) Group size, provided the highest rate factor associated with
1740 group size shall not vary from the lowest rate factor associated with
1741 group size by a ratio of greater than 1.25 to 1.0;

1742 (vi) Administrative cost savings resulting from the administration of
1743 an association group plan or a plan written pursuant to section 5-259,
1744 as amended by this act, provided the savings reflect a reduction to the
1745 small employer carrier's overall retention that is measurable and

1746 specifically realized on items such as marketing, billing or claims
1747 paying functions taken on directly by the plan administrator or
1748 association, except that such savings may not reflect a reduction
1749 realized on commissions;

1750 (vii) Savings resulting from a reduction in the profit of a carrier
1751 [who] that writes small business plans or arrangements for an
1752 association group plan or a plan written pursuant to section 5-259, as
1753 amended by this act, provided any loss in overall revenue due to a
1754 reduction in profit is not shifted to other small employers; and

1755 (viii) Family composition, provided the small employer carrier shall
1756 utilize only one or more of the following billing classifications: (I)
1757 Employee; (II) employee plus family; (III) employee and spouse; (IV)
1758 employee and child; (V) employee plus one dependent; and (VI)
1759 employee plus two or more dependents.

1760 [(B) The small employer carrier shall quote premium rates to small
1761 employers after receipt of all demographic rating classifications of the
1762 small employer group. No small employer carrier may inquire
1763 regarding health status or claims experience of the small employer or
1764 its employees or dependents prior to the quoting of a premium rate.

1765 (C) The provisions of subparagraphs (A) and (B) of this subdivision
1766 shall apply to plans or arrangements issued on or after July 1, 1995.
1767 The provisions of subparagraphs (A) and (B) of this subdivision shall
1768 apply to plans or arrangements issued prior to July 1, 1995, as of the
1769 date of the first rating period commencing on or after that date, but no
1770 later than July 1, 1996.

1771 (6) For any small employer plan or arrangement on which the
1772 premium rates for employee and dependent coverage or both, vary
1773 among employees, such variations shall be based solely on age and
1774 other demographic factors permitted under subparagraph (A) of
1775 subdivision (5) of this section and such variations may not be based on
1776 health status, claim experience, or duration of coverage of specific

1777 enrollees. Except as otherwise provided in subdivision (1) of this
1778 section, any adjustment in premium rates charged for a small
1779 employer plan or arrangement to reflect changes in case characteristics
1780 prior to the end of a rating period shall not include any adjustment to
1781 reflect the health status, medical history or medical underwriting
1782 classification of any new enrollee for whom coverage begins during
1783 the rating period.

1784 (7) For rating periods commencing prior to July 1, 1995, in any case
1785 where a small employer carrier utilized industry classification as a case
1786 characteristic in establishing premium rates, the rate factor associated
1787 with any industry classification shall not vary from the arithmetical
1788 average of the highest and lowest rate factors associated with all
1789 industry classifications by greater than fifteen per cent of such average.

1790 (8) Differences in base premium rates charged for health benefit
1791 plans by a small employer carrier shall be reasonable and reflect
1792 objective differences in plan design, not including differences due to
1793 the nature of the groups assumed to select particular health benefit
1794 plans.

1795 (9) For rating periods commencing prior to July 1, 1995, in any case
1796 where an insurer issues or offers a policy or contract under which
1797 premium rates for a specific small employer are established or
1798 adjusted in part based upon the actual or expected variation in claim
1799 costs or actual or expected variation in health conditions of the
1800 employees or dependents of such small employer, the insurer shall
1801 make reasonable disclosure of such rating practices in solicitation and
1802 sales materials utilized with respect to such policy or contract.

1803 (10) If a small employer carrier denies coverage as requested to a
1804 small employer that is self-employed, the small employer carrier shall
1805 promptly offer such small employer the opportunity to purchase a
1806 small employer health care plan. If a small employer carrier or any
1807 producer representing that carrier fails, for any reason, to offer

1808 coverage as requested by a small employer that is self-employed, that
1809 small employer carrier shall promptly offer such small employer an
1810 opportunity to purchase a small employer health care plan.]

1811 (C) (i) With respect to nongrandfathered plans issued to small
1812 employers, the premium rates charged or offered shall be established
1813 on the basis of a single pool of all nongrandfathered plans, adjusted to
1814 reflect one or more of the following classifications:

1815 (I) Age, in accordance with a uniform age rating curve established
1816 by the commissioner;

1817 (II) Geographic area, as defined by the commissioner.

1818 (ii) Total premium rates for family coverage for nongrandfathered
1819 plans shall be determined by adding the premiums for each individual
1820 family member, except that with respect to family members under
1821 twenty-one years of age, the premiums for only the three oldest
1822 covered children shall be taken into account in determining the total
1823 premium rate for such family.

1824 (iii) Premium rates for employees and dependents for
1825 nongrandfathered plans shall be calculated for each covered individual
1826 and premium rates for the small employer group shall be calculated by
1827 totaling the premiums attributable to each covered individual.

1828 (iv) Premium rates for any given plan may vary by actuarially
1829 justified differences in plan design.

1830 ~~[(11)]~~ (3) No small employer carrier or producer shall, directly or
1831 indirectly, engage in the following activities:

1832 (A) Encouraging or directing small employers to refrain from filing
1833 an application for coverage with the small employer carrier because of
1834 the health status, claims experience, industry, occupation or
1835 geographic location of the small employer, except the provisions of
1836 this subparagraph shall not apply to information provided by a small

1837 employer carrier or producer to a small employer regarding the
1838 carrier's established geographic service area or a restricted network
1839 provision of a small employer carrier; or

1840 (B) Encouraging or directing small employers to seek coverage from
1841 another carrier because of the health status, claims experience,
1842 industry, occupation or geographic location of the small employer.

1843 [(12)] (4) No small employer carrier shall, directly or indirectly,
1844 enter into any contract, agreement or arrangement with a producer
1845 that provides for or results in the compensation paid to a producer for
1846 the sale of a health benefit plan to be varied because of the health
1847 status, claims experience, industry, occupation or geographic area of
1848 the small employer. A small employer carrier shall provide reasonable
1849 compensation, as provided under the plan of operation of the
1850 program, to a producer, if any, for the sale of a [special or a small
1851 employer] health care plan. No small employer carrier shall terminate,
1852 fail to renew or limit its contract or agreement of representation with a
1853 producer for any reason related to the health status, claims experience,
1854 occupation, or geographic location of the small employers placed by
1855 the producer with the small employer carrier.

1856 [(13)] (5) No small employer carrier or producer shall induce or
1857 otherwise encourage a small employer to separate or otherwise
1858 exclude an employee from health coverage or benefits provided in
1859 connection with the employee's employment.

1860 [(14) Denial by a small employer carrier of an application for
1861 coverage from a small employer shall be in writing and shall state the
1862 reasons for the denial.]

1863 [(15)] (6) No small employer carrier or producer shall disclose (A) to
1864 a small employer the fact that any or all of the eligible employees of
1865 such small employer have been or will be reinsured with the pool, or
1866 (B) to any eligible employee or dependent the fact that he has been or
1867 will be reinsured with the pool.

1868 [(16)] (7) If a small employer carrier enters into a contract,
1869 agreement or other arrangement with another party to provide
1870 administrative, marketing or other services related to the offering of
1871 health benefit plans to small employers in this state, the other party
1872 shall be subject to the provisions of this section.

1873 [(17)] (8) The commissioner may adopt regulations, in accordance
1874 with the provisions of chapter 54, setting forth additional standards to
1875 provide for the fair marketing and broad availability of health benefit
1876 plans to small employers.

1877 [(18) Each small employer carrier shall maintain at its principal
1878 place of business a complete and detailed description of its rating
1879 practices and renewal underwriting practices, including information
1880 and documentation that demonstrates that its rating methods and
1881 practices are based upon commonly accepted actuarial assumptions
1882 and are in accordance with sound actuarial principles. Each small
1883 employer carrier shall file with the commissioner annually, on or
1884 before March fifteenth, an actuarial certification certifying that the
1885 carrier is in compliance with this part and that the rating methods have
1886 been derived using recognized actuarial principles consistent with the
1887 provisions of sections 38a-564 to 38a-573, inclusive. Such certification
1888 shall be in a form and manner and shall contain such information as
1889 determined by the commissioner. A copy of the certification shall be
1890 retained by the small employer carrier at its principal place of
1891 business. Any information and documentation described in this
1892 subdivision but not subject to the filing requirement shall be made
1893 available to the commissioner upon his request. Except in cases of
1894 violations of sections 38a-564 to 38a-573, inclusive, the information
1895 shall be considered proprietary and trade secret information and shall
1896 not be subject to disclosure by the commissioner to persons outside of
1897 the department except as agreed to by the small employer carrier or as
1898 ordered by a court of competent jurisdiction.

1899 (19) The commissioner may suspend all or any part of this section

1900 relating to the premium rates applicable to one or more small
1901 employers for one or more rating periods upon a filing by the small
1902 employer carrier and a finding by the commissioner that either the
1903 suspension is reasonable in light of the financial condition of the
1904 carrier or that the suspension would enhance the efficiency and
1905 fairness of the marketplace for small employer health insurance.

1906 (20) For rating periods commencing prior to July 1, 1995, a small
1907 employer carrier shall quote premium rates to any small employer
1908 within thirty days after receipt by the carrier of such employer's
1909 completed application.]

1910 [(21)] (9) Any violation of subdivisions [(10) to (16)] (3) to (7),
1911 inclusive, of this section and of any regulations established under
1912 subdivision [(17)] (8) of this section shall be an unfair and prohibited
1913 practice under sections 38a-815 to 38a-830, inclusive.

1914 [(22) (A) With respect to plans or arrangements issued pursuant to
1915 subsection (i) of section 5-259, at the option of the Comptroller, the
1916 premium rates charged or offered to small employers purchasing
1917 health insurance shall not be subject to this section, provided (i) the
1918 plan or plans offered or issued cover such small employers as a single
1919 entity and cover not less than three thousand employees on the date
1920 issued, (ii) each small employer is charged or offered the same
1921 premium rate with respect to each employee and dependent, and (iii)
1922 the plan or plans are written on a guaranteed issue basis.

1923 (B) With respect to plans or arrangements issued by an association
1924 group plan, at the option of the administrator of the association group
1925 plan, the premium rates charged or offered to small employers
1926 purchasing health insurance shall not be subject to this section,
1927 provided (i) the plan or plans offered or issued cover such small
1928 employers as a single entity and cover not less than three thousand
1929 employees on the date issued, (ii) each small employer is charged or
1930 offered the same premium rate with respect to each employee and

1931 dependent, and (iii) the plan or plans are written on a guaranteed issue
1932 basis. In addition, such association group (I) shall be a bona fide group
1933 as set forth in the Employee Retirement and Security Act of 1974, (II)
1934 shall not be formed for the purposes of fictitious grouping, as defined
1935 in section 38a-827, and (III) shall not issue any plan that shall cause
1936 undue disruption in the insurance marketplace, as determined by the
1937 commissioner.]

1938 Sec. 20. Subparagraph (C) of subdivision (2) of section 38a-567 of the
1939 general statutes, as amended by section 19 of this act, is repealed and
1940 the following is substituted in lieu thereof (*Effective January 1, 2016*):

1941 (C) (i) With respect to nongrandfathered plans issued to small
1942 employers, the premium rates charged or offered shall be established
1943 on the basis of a single pool of all nongrandfathered plans, adjusted to
1944 reflect one or more of the following classifications:

1945 (I) Age, in accordance with a uniform age rating curve established
1946 by the commissioner;

1947 (II) Geographic area, as defined by the commissioner.

1948 (ii) Total premium rates for family coverage for nongrandfathered
1949 plans shall be determined by adding the premiums for each individual
1950 family member, except that with respect to family members under
1951 twenty-one years of age, the premiums for only the three oldest
1952 covered children shall be taken into account in determining the total
1953 premium rate for such family.

1954 (iii) Premium rates for employees and dependents for
1955 nongrandfathered plans shall be calculated for each covered individual
1956 and premium rates for the small employer group shall be calculated by
1957 totaling the premiums attributable to each covered individual.

1958 (iv) Premium rates for any given plan may vary by (I) actuarially
1959 justified differences in plan design, and (II) actuarially justified

1960 amounts to reflect the policy's provider network and administrative
1961 expense differences that can be reasonably allocated to such policy.

1962 Sec. 21. Section 38a-569 of the general statutes is repealed and the
1963 following is substituted in lieu thereof (*Effective from passage*):

1964 (a) (1) There is established a nonprofit entity to be known as the
1965 "Connecticut Small Employer Health Reinsurance Pool". All insurers
1966 issuing health insurance in this state and insurance arrangements
1967 providing health plan benefits in this state on and after July 1, 1990,
1968 shall be members of the pool.

1969 (2) On or before July 15, 1990, the commissioner shall give notice to
1970 all insurers and insurance arrangements of the time and place for the
1971 initial organizational meeting, which shall take place by September 1,
1972 1990. The members shall select the initial board, subject to approval by
1973 the commissioner. The board shall consist of at least five and not more
1974 than nine representatives of members. There shall be no more than two
1975 members of the board representing any one insurer or insurance
1976 arrangement. In determining voting rights at the organizational
1977 meeting, each member shall be entitled to vote in person or by proxy.
1978 The vote shall be weighted based upon net health insurance premium
1979 derived from this state in the previous calendar year. To the extent
1980 possible, at least one-third of the members of the board shall be
1981 domestic insurance companies and at least two-thirds of the members
1982 of the board shall be small employer carriers. At least one member of
1983 the board shall be a health care center and at least one member shall be
1984 a small employer carrier with less than one hundred million dollars in
1985 net small employer health insurance premium in this state. The
1986 Insurance Commissioner shall be an ex-officio member of the board.
1987 The net premium amount shall be adjusted by the board periodically
1988 for health care cost inflation. In approving selection of the board, the
1989 commissioner shall assure that all members are fairly represented. The
1990 membership of all boards subsequent to the initial board shall, to the
1991 extent possible, reflect the same distribution of representation as is

1992 described in this subdivision.

1993 (3) If the initial board is not elected at the organizational meeting,
1994 the commissioner shall appoint the initial board within fifteen days of
1995 the organizational meeting.

1996 (4) Within ninety days after the appointment of such initial board,
1997 the board shall submit to the commissioner a plan of operation and
1998 thereafter any amendments thereto necessary or suitable to assure the
1999 fair, reasonable and equitable administration of the pool. The
2000 commissioner shall, after notice and hearing, approve the plan of
2001 operation provided he determines it to be suitable to assure the fair,
2002 reasonable and equitable administration of the pool, and provides for
2003 the sharing of pool gains or losses on an equitable proportionate basis
2004 in accordance with the provisions of subsection (d) of this section,
2005 revision of 1958, revised to January 1, 2013. The plan of operation shall
2006 become effective upon approval in writing by the commissioner
2007 consistent with the date on which the coverage under this section shall
2008 be made available. If the board fails to submit a suitable plan of
2009 operation within one hundred eighty days after its appointment, or at
2010 any time thereafter fails to submit suitable amendments to the plan of
2011 operation, the commissioner shall, after notice and hearing, adopt and
2012 promulgate a plan of operation or amendments, as appropriate. The
2013 commissioner shall amend any plan adopted by him, as necessary, at
2014 the time a plan of operation is submitted by the board and approved
2015 by the commissioner.

2016 (5) [The] On and after the effective date of this section, the plan of
2017 operation shall establish procedures for: (A) Handling and accounting
2018 of assets and moneys of the pool, and for an annual fiscal reporting to
2019 the commissioner; (B) filling vacancies on the board, subject to the
2020 approval of the commissioner; (C) selecting an administrator and
2021 setting forth the powers and duties of the administrator; (D) reinsuring
2022 risks; [in accordance with the provisions of this section;] (E) collecting
2023 assessments from all members to provide for claims reinsured by the

2024 pool and for administrative expenses incurred or estimated to be
2025 incurred during the period for which the assessment is made; and (F)
2026 any additional matters at the discretion of the board.

2027 (6) The pool shall have the general powers and authority granted
2028 under the laws of Connecticut to insurance companies licensed to
2029 transact health insurance and, in addition thereto, the specific
2030 authority to: (A) Enter into contracts as are necessary or proper to
2031 carry out the provisions and purposes of this section, including the
2032 authority, with the approval of the commissioner, to enter into
2033 contracts with programs of other states for the joint performance of
2034 common functions, or with persons or other organizations for the
2035 performance of administrative functions; (B) sue or be sued, including
2036 taking any legal actions necessary or proper for recovery of any
2037 assessments for, on behalf of, or against members; (C) take such legal
2038 action as necessary to avoid the payment of improper claims against
2039 the pool; (D) define the array of health coverage products for which
2040 reinsurance will be provided, and to issue reinsurance policies, in
2041 accordance with the requirements of this section; (E) establish rules,
2042 conditions and procedures pertaining to the reinsurance of members'
2043 risks by the pool; (F) establish appropriate rates, rate schedules, rate
2044 adjustments, rate classifications and any other actuarial functions
2045 appropriate to the operation of the pool; (G) assess members in
2046 accordance with the provisions of subsection [(e)] (c) of this section,
2047 and to make advance interim assessments as may be reasonable and
2048 necessary for organizational and interim operating expenses. Any such
2049 interim assessments shall be credited as offsets against any regular
2050 assessments due following the close of the fiscal year; (H) appoint from
2051 among members appropriate legal, actuarial and other committees as
2052 necessary to provide technical assistance in the operation of the pool,
2053 policy and other contract design, and any other function within the
2054 authority of the pool; and (I) borrow money to effect the purposes of
2055 the pool. Any notes or other evidence of indebtedness of the pool not
2056 in default shall be legal investments for insurers and may be carried as

2057 admitted assets.

2058 (b) Any member whose health insurance plan is subject to section
2059 38a-567, as amended by this act, may reinsure with the pool coverage
2060 of an eligible employee of a small employer [,] or any dependent of
2061 such an employee. [, except that no member may reinsure with the
2062 pool coverage of an eligible employee of a small employer, or any
2063 dependent of such an employee, whose premium rates are not subject
2064 to section 38a-567 pursuant to subdivision (22) of section 38a-567. Any
2065 reinsurance placed with the pool from the date of the establishment of
2066 the pool regarding the coverage of an eligible employee of a small
2067 employer, or any dependent of such an employee shall be provided as
2068 follows:]

2069 [(1) (A) With respect to a special health care plan or a small
2070 employer health care plan, the pool shall reinsure the level of coverage
2071 provided; (B) with respect to other plans, the pool shall reinsure the
2072 level of coverage provided up to, but not exceeding, the level of
2073 coverage provided in a small employer health care plan or the
2074 actuarial equivalent thereof as defined and authorized by the board;
2075 and (C) in either case, no reinsurance may be provided in any calendar
2076 year for a reinsured employee or dependent until five thousand dollars
2077 in benefit payments have been made for services provided during that
2078 calendar year for that reinsured employee or dependent, which
2079 payments would have been reimbursed through said reinsurance in
2080 the absence of the annual five-thousand-dollar deductible. The amount
2081 of the deductible shall be periodically reviewed by the board and may
2082 be adjusted for appropriate factors as determined by the board;

2083 (2) With respect to eligible employees, and their dependents,
2084 coverage may be reinsured: (A) Within such period of time after the
2085 commencement of their coverage under the plan as may be authorized
2086 by the board, or (B) commencing January 1, 1992, on the first plan
2087 anniversary after the employer's coverage has been in effect with the
2088 small employer carrier for a period of three years, and every third plan

2089 anniversary thereafter, provided, commencing May 1, 1994,
2090 reinsurance pursuant to this subparagraph shall only be permitted
2091 with respect to eligible employees and their dependents of a small
2092 employer which has no more than two eligible employees as of the
2093 applicable anniversary;

2094 (3) Reinsurance coverage may be terminated for each reinsured
2095 employee or dependent on any plan anniversary;

2096 (4) Reinsurance of newborn dependents shall be allowed only if the
2097 mother of any such dependent is reinsured as of the date of birth of
2098 such child, and all newborn dependents of reinsured persons shall be
2099 automatically reinsured as of their date of birth; and

2100 (5) Notwithstanding the provisions of subparagraph (A) of
2101 subdivision (2) of this subsection: (A) Coverage for eligible employees
2102 and their dependents provided under a group policy covering two or
2103 more small employers shall not be eligible for reinsurance when such
2104 coverage is discontinued and replaced by a group policy of another
2105 carrier covering two or more small employers, unless coverage for
2106 such eligible employees or dependents was reinsured by the prior
2107 carrier; and (B) at the time coverage is assumed for such group by a
2108 succeeding carrier, such carrier shall notify the pool of its intention to
2109 provide coverage for such group and shall identify the employees and
2110 dependents whose coverage will continue to be reinsured. The time
2111 limitations for providing such notice shall be established by the pool.

2112 (c) Except as provided in subsection (d) of this section, premium
2113 rates charged for reinsurance by the pool shall be established at the
2114 following percentages of the rate established by the pool for that
2115 classification or group with similar characteristics and coverage:

2116 (1) One hundred fifty per cent, with respect to all of the eligible
2117 employees, and their dependents, of a small employer, all of whose
2118 coverage is reinsured in accordance with subdivision (2) of subsection
2119 (b) of this section; and

2120 (2) Five hundred per cent, with respect to an eligible employee or
2121 dependent who is individually reinsured in accordance with
2122 subdivision (2) of subsection (b) of this section and is not reinsured
2123 with all eligible employees of an employer and their dependents.

2124 (d) Premium rates charged for reinsurance by the pool to a health
2125 care center which is approved by the Secretary of Health and Human
2126 Services as a health maintenance organization pursuant to 42 USC 300
2127 et seq., and as such is subject to requirements that limit the amount of
2128 risk that may be ceded to the pool, may be modified by the board, if
2129 appropriate, to reflect the portion of risk that may be ceded to the
2130 pool.]

2131 [(e)] (c) (1) Following the close of each fiscal year, the administrator
2132 shall determine the net premiums, the pool expenses of administration
2133 and the incurred losses for the year, taking into account investment
2134 income and other appropriate gains and losses. For purposes of this
2135 section, health insurance premiums earned by insurance arrangements
2136 shall be established by adding paid health losses and administrative
2137 expenses of the insurance arrangement. Health insurance premiums
2138 and benefits paid by a member that are less than an amount
2139 determined by the board to justify the cost of collection shall not be
2140 considered for purposes of determining assessments. For purposes of
2141 this subsection, "net premiums" means health insurance premiums,
2142 less administrative expense allowances.

2143 (2) Any net loss for the year shall be recouped by assessments of
2144 members.

2145 (A) Assessments shall first be apportioned by the board among all
2146 members in proportion to their respective shares of the total health
2147 insurance premiums earned in this state from health insurance plans
2148 and insurance arrangements covering small employers during the
2149 calendar year coinciding with or ending during the fiscal year of the
2150 pool, or on any other equitable basis reflecting coverage of small

2151 employers as may be provided in the plan of operations. An
2152 assessment shall be made pursuant to this subparagraph against a
2153 health care center, [which] that is approved by the Secretary of Health
2154 and Human Services as a health maintenance organization pursuant to
2155 42 USC 300e et seq., subject to an assessment adjustment formula
2156 adopted by the board and approved by the commissioner for such
2157 health care centers [which] that recognizes the restrictions imposed on
2158 such health care centers by federal law. Such adjustment formula shall
2159 be adopted by the board and approved by the commissioner prior to
2160 the first anniversary of the pool's operation.

2161 (B) If such net loss is not recouped before assessments totaling five
2162 per cent of such premiums from plans and arrangements covering
2163 small employers have been collected, additional assessments shall be
2164 apportioned by the board among all members in proportion to their
2165 respective shares of the total health insurance premiums earned in this
2166 state from other individual and group plans and arrangements,
2167 exclusive of any individual Medicare supplement policies as defined in
2168 section 38a-495 during such calendar year.

2169 (C) Notwithstanding the provisions of this subdivision, the
2170 assessments to any one member under subparagraph (A) or (B) of this
2171 subdivision shall not exceed forty per cent of the total assessment
2172 under each subparagraph for the first fiscal year of the pool's operation
2173 and fifty per cent of the total assessment under each subparagraph for
2174 the second fiscal year. Any amounts abated pursuant to this
2175 subparagraph shall be assessed against the other members in a manner
2176 consistent with the basis for assessments set forth in this subdivision.

2177 (3) If assessments exceed actual losses and administrative expenses
2178 of the pool, the excess shall be held at interest and used by the board to
2179 offset future losses or to reduce pool premiums. As used in this
2180 subsection, "future losses" includes reserves for incurred but not
2181 reported claims.

2182 (4) Each member's proportion of participation in the pool shall be
2183 determined annually by the board based on annual statements and
2184 other reports deemed necessary by the board and filed by the member
2185 with it. Insurance arrangements shall report to the board claims
2186 payments made and administrative expenses incurred in this state on
2187 an annual basis on a form prescribed by the commissioner.

2188 (5) Provision shall be made in the plan of operation for the
2189 imposition of an interest penalty for late payment of assessments.

2190 (6) The board may defer, in whole or in part, the assessment of a
2191 health care center if, in the opinion of the board: (A) Payment of the
2192 assessment would endanger the ability of the health care center to
2193 fulfill its contractual obligations, or (B) in accordance with standards
2194 included in the plan of operation, the health care center has written,
2195 and reinsured in their entirety, a disproportionate number of special
2196 health care plans. In the event an assessment against a health care
2197 center is deferred in whole or in part, the amount by which such
2198 assessment is deferred may be assessed against the other members in a
2199 manner consistent with the basis for assessments set forth in this
2200 subsection. The health care center receiving such deferment shall
2201 remain liable to the pool for the amount deferred. The board may
2202 attach appropriate conditions to any such deferment.

2203 ~~[(f) (1) Neither the]~~ (d) (1) The participation in the pool as members,
2204 the establishment of rates, forms or procedures ~~[nor]~~ or any other joint
2205 or collective action required by this section shall not be the basis of any
2206 legal action, criminal or civil liability or penalty against the pool or any
2207 of its members.

2208 (2) Any person or member made a party to any action, suit or
2209 proceeding because the person or member served on the board or on a
2210 committee or was an officer or employee of the pool shall be held
2211 harmless and be indemnified by the program against all liability and
2212 costs, including the amounts of judgments, settlements, fines or

2213 penalties, and expenses and reasonable attorney's fees incurred in
2214 connection with the action, suit or proceeding. The indemnification
2215 shall not be provided on any matter in which the person or member is
2216 finally adjudged in the action, suit or proceeding to have committed a
2217 breach of duty involving gross negligence, dishonesty, wilful
2218 misfeasance or reckless disregard of the responsibilities of office. Costs
2219 and expenses of the indemnification shall be prorated and paid for by
2220 all members. The Insurance Commissioner may retain actuarial
2221 consultants necessary to carry out said commissioner's responsibilities
2222 pursuant to [sections 38a-564 to 38a-572, inclusive] this section, section
2223 38a-564, as amended by this act, 38a-566, as amended by this act, or
2224 38a-567, as amended by this act, and such expenses shall be paid by
2225 the pool established in this section.

2226 Sec. 22. Section 38a-574 of the general statutes is repealed and the
2227 following is substituted in lieu thereof (*Effective from passage*):

2228 (a) [On or before July 1, 1993, the] The board of directors of the
2229 Connecticut Small Employer Health Reinsurance Pool shall establish,
2230 subject to the approval of the Insurance Commissioner, a standard
2231 [underwriting form] family health statement for use by small employer
2232 carriers [for medical underwriting of health insurance plans and
2233 insurance arrangements covering small employers, as defined in
2234 section 38a-564. Within] to determine whether to cede lives to the
2235 reinsurance pool. Not later than ninety days after approval by the
2236 Insurance Commissioner of the [standard underwriting form] family
2237 health statement, the board shall require every small employer carrier,
2238 as a condition of transacting such business in this state, to use the
2239 [form for medical underwriting of] statement for such plans and
2240 arrangements.

2241 (b) The [form] statement may be amended from time to time as the
2242 board deems necessary, subject to the approval of the Insurance
2243 Commissioner.

2244 Sec. 23. Section 38a-543 of the general statutes is repealed and the
2245 following is substituted in lieu thereof (*Effective from passage*):

2246 [No individual, partnership, corporation or unincorporated
2247 association which employs less than twenty employees and provides
2248 group hospital, surgical or medical insurance coverage for its
2249 employees may reduce the coverage provided to any employee or any
2250 employee's spouse solely because he has reached the age of sixty-five
2251 and is eligible for Medicare benefits except to the extent such coverage
2252 is provided by Medicare. The terms of any such plan provided by any
2253 such employer which employs twenty or more employees shall entitle
2254 any employee who has attained the age of sixty-five and any
2255 employee's spouse who has attained the age of sixty-five to group
2256 hospital, surgical or medical insurance coverage under the same
2257 conditions as any covered employee or spouse who is under the age of
2258 sixty-five.] No group health insurance policy delivered, issued for
2259 delivery, renewed, amended or continued in this state shall include
2260 any provision that reduces payments on the basis that an individual is
2261 eligible for Medicare by reason of age, disability or end-stage renal
2262 disease, unless such individual enrolls in Medicare. If such individual
2263 enrolls in Medicare, any such reduction shall be only to the extent such
2264 coverage is provided by Medicare.

2265 Sec. 24. Subsection (f) of section 5-248a of the general statutes is
2266 repealed and the following is substituted in lieu thereof (*Effective from*
2267 *passage*):

2268 (f) [Notwithstanding the provisions of subsection (b) of section 38a-
2269 554, the] The state shall pay for the continuation of health insurance
2270 benefits for the employee during any leave of absence taken pursuant
2271 to this section. In order to continue any other health insurance
2272 coverages during such leave, the employee shall contribute that
2273 portion of the premium the employee would have been required to
2274 contribute had the employee remained an active employee during the
2275 leave period.

2276 Sec. 25. Subsection (i) of section 5-259 of the general statutes is
2277 repealed and the following is substituted in lieu thereof (*Effective from*
2278 *passage*):

2279 (i) The Comptroller may provide for coverage of employees of
2280 municipalities, nonprofit corporations, community action agencies and
2281 small employers and individuals eligible for a health coverage tax
2282 credit, retired members or members of an association for personal care
2283 assistants under the plan or plans procured under subsection (a) of this
2284 section, provided: (1) Participation by each municipality, nonprofit
2285 corporation, community action agency, small employer, eligible
2286 individual, retired member or association for personal care assistants
2287 shall be on a voluntary basis; (2) where an employee organization
2288 represents employees of a municipality, nonprofit corporation,
2289 community action agency or small employer, participation in a plan or
2290 plans to be procured under subsection (a) of this section shall be by
2291 mutual agreement of the municipality, nonprofit corporation,
2292 community action agency or small employer and the employee
2293 organization only and neither party may submit the issue of
2294 participation to binding arbitration except by mutual agreement if
2295 such binding arbitration is available; (3) no group of employees shall
2296 be refused entry into the plan by reason of past or future health care
2297 costs or claim experience; (4) rates paid by the state for its employees
2298 under subsection (a) of this section are not adversely affected by this
2299 subsection; (5) administrative costs to the plan or plans provided
2300 under this subsection shall not be paid by the state; (6) participation in
2301 the plan or plans in an amount determined by the state shall be for the
2302 duration of the period of the plan or plans, or for such other period as
2303 mutually agreed by the municipality, nonprofit corporation,
2304 community action agency, small employer, retired member or
2305 association for personal care assistants and the Comptroller; and (7)
2306 nothing in this section or section 12-202a, 38a-551, as amended by this
2307 act, [38a-553] or 38a-556, as amended by this act, shall be construed as
2308 requiring a participating insurer or health care center to issue

2309 individual policies to individuals eligible for a health coverage tax
2310 credit. The coverage provided under this section may be referred to as
2311 the "Municipal Employee Health Insurance Plan". The Comptroller
2312 may arrange and procure for the employees and eligible individuals
2313 under this subsection health benefit plans that vary from the plan or
2314 plans procured under subsection (a) of this section. Notwithstanding
2315 any provision of part V of chapter 700c, the coverage provided under
2316 this subsection may be offered on either a fully underwritten or risk-
2317 pooled basis at the discretion of the Comptroller. For the purposes of
2318 this subsection, (A) "municipality" means any town, city, borough,
2319 school district, taxing district, fire district, district department of
2320 health, probate district, housing authority, regional work force
2321 development board established under section 31-3k, regional
2322 emergency telecommunications center, tourism district established
2323 under section 32-302, flood commission or authority established by
2324 special act, regional council of governments, transit district formed
2325 under chapter 103a, or the Children's Center established by number
2326 571 of the public acts of 1969; (B) "nonprofit corporation" means (i) a
2327 nonprofit corporation organized under 26 USC 501 that has a contract
2328 with the state or receives a portion of its funding from a municipality,
2329 the state or the federal government, or (ii) an organization that is tax
2330 exempt pursuant to 26 USC 501(c)(5); (C) "community action agency"
2331 means a community action agency, as defined in section 17b-885; (D)
2332 "small employer" means a small employer, as defined in
2333 [subparagraph (A) of subdivision (4) of] section 38a-564, as amended
2334 by this act; (E) "eligible individuals" or "individuals eligible for a health
2335 coverage tax credit" means individuals who are eligible for the credit
2336 for health insurance costs under Section 35 of the Internal Revenue
2337 Code of 1986, or any subsequent corresponding internal revenue code
2338 of the United States, as from time to time amended, in accordance with
2339 the Pension Benefit Guaranty Corporation; [and Trade Adjustment
2340 Assistance programs of the Trade Act of 2002 (P.L. 107-210);] (F)
2341 "association for personal care assistants" means an organization
2342 composed of personal care attendants who are employed by recipients

2343 of service (i) under the home-care program for the elderly under
2344 section 17b-342, (ii) under the personal care assistance program under
2345 section 17b-605a, (iii) in an independent living center pursuant to
2346 sections 17b-613 to 17b-615, inclusive, or (iv) under the program for
2347 individuals with acquired brain injury as described in section 17b-
2348 260a; and (G) "retired members" means individuals eligible for a
2349 retirement benefit from the Connecticut municipal employees'
2350 retirement system.

2351 Sec. 26. Subdivision (7) of section 12-201 of the general statutes is
2352 repealed and the following is substituted in lieu thereof (*Effective from*
2353 *passage*):

2354 (7) "Gross direct premiums" means all receipts of premiums from
2355 policyholders and applicants for policies, whether received in the form
2356 of money or other valuable consideration, but excluding annuity
2357 premiums and considerations and premiums received for reinsurances
2358 assumed from other insurance companies; [and premiums received
2359 after July 1, 1990, and before January 1, 1995, for any special health
2360 care plan, as defined in section 38a-564;]

2361 Sec. 27. Subsection (c) of section 12-211 of the general statutes is
2362 repealed and the following is substituted in lieu thereof (*Effective from*
2363 *passage*):

2364 (c) The provisions of this section shall not apply to ad valorem taxes
2365 on real or personal property, personal income taxes, fees for agents'
2366 licenses, special purpose assessments imposed in connection with
2367 particular kinds of insurance including, but not limited to, workers'
2368 compensation assessments and Insurance Guaranty Association Fund
2369 assessments, or to premium taxes on special health care plans as
2370 defined in [section] sections 38a-564, revision of 1958, revised to
2371 January 1, 2013, and 38a-551, as amended by this act, except in the case
2372 where another state or foreign country imposes upon Connecticut
2373 domiciled insurers retaliatory charges for such taxes, fees or

2374 assessments.

2375 Sec. 28. Section 12-212a of the general statutes is repealed and the
2376 following is substituted in lieu thereof (*Effective from passage*):

2377 All corporations organized under sections 38a-199 to 38a-209,
2378 inclusive, and 38a-214 to 38a-225, inclusive, shall pay to the
2379 Commissioner of Revenue Services on or before March first, annually,
2380 a charge at the rate of two per cent of the total net direct subscriber
2381 charges [, excluding those net direct subscriber charges received after
2382 July 1, 1990, and before January 1, 1995, from employers for any special
2383 health care plan, as defined in section 38a-564,] received by such
2384 corporation during the next preceding calendar year, which shall be in
2385 addition to any other payment required under section 38a-48. The
2386 charge required under this section and any other payment required
2387 under said section 38a-48 shall be in compensation for the costs and
2388 expenses of regulation by the Insurance Department and all other
2389 governmental services. The provisions of this chapter pertaining to the
2390 filing of returns, declarations, assessment and collection of taxes, and
2391 penalties imposed on domestic insurance companies shall apply with
2392 respect to the charge imposed under this section, provided
2393 corporations subject to the charge imposed under this section shall not
2394 be subject to any tax imposed under this chapter.

2395 Sec. 29. Subsection (e) of section 17b-265 of the general statutes is
2396 repealed and the following is substituted in lieu thereof (*Effective from*
2397 *passage*):

2398 (e) [Notwithstanding the provisions of subsection (c) of section 38a-
2399 553, no] No self-insured plan, group health plan, as defined in Section
2400 607(1) of the Employee Retirement Income Security Act of 1974, service
2401 benefit plan, managed care plan, or any plan offered or administered
2402 by a health care center, pharmacy benefit manager, dental benefit
2403 manager, third-party administrator or other party that is, by statute,
2404 contract or agreement, legally responsible for payment of a claim for a

2405 health care item or service, shall contain any provision that has the
2406 effect of denying or limiting enrollment benefits or excluding coverage
2407 because services are rendered to an insured or beneficiary who is
2408 eligible for or who received medical assistance under this chapter. No
2409 insurer, as defined in section 38a-497a, shall impose requirements on
2410 the state Medicaid agency, which has been assigned the rights of an
2411 individual eligible for Medicaid and covered for health benefits from
2412 an insurer, that differ from requirements applicable to an agent or
2413 assignee of another individual so covered.

2414 Sec. 30. Subsection (c) of section 17b-284 of the general statutes is
2415 repealed and the following is substituted in lieu thereof (*Effective from*
2416 *passage*):

2417 (c) The commissioner may pay under the Medicaid program, within
2418 available appropriations, the premiums for continued health insurance
2419 coverage under an employer's group health insurance plan, pursuant
2420 to section [38a-554] 38a-512a, as amended by this act, for chronically ill
2421 and disabled persons who are no longer employed and would
2422 otherwise be eligible for Medicaid.

2423 Sec. 31. Subdivision (6) of subsection (c) of section 17b-299 of the
2424 general statutes is repealed and the following is substituted in lieu
2425 thereof (*Effective from passage*):

2426 (6) Expiration of the continuation of coverage periods set forth in
2427 section [38a-554] 38a-512a, as amended by this act;

2428 Sec. 32. Subsection (b) of section 17b-611 of the general statutes is
2429 repealed and the following is substituted in lieu thereof (*Effective from*
2430 *passage*):

2431 (b) The contract shall provide the same benefits as are provided
2432 under contracts issued pursuant to sections 38a-505, as amended by
2433 this act, 38a-546, 38a-551, as amended by this act, and 38a-556 to 38a-
2434 559, inclusive, as amended by this act, except mental and nervous

2435 disorders shall be covered in accordance with section 38a-514.

2436 Sec. 33. Subsection (b) of section 19a-7b of the general statutes is
2437 repealed and the following is substituted in lieu thereof (*Effective from*
2438 *passage*):

2439 (b) The commission shall develop the design, administrative,
2440 actuarial and financing details of program initiatives necessary to
2441 attain the goal described in section 19a-7a. [The commission shall
2442 study the experience of the state under the programs and policies
2443 developed pursuant to sections 12-201, 12-211, 12-212a, 17b-277, 17b-
2444 282 to 17b-284, inclusive, 17b-611, 19a-7a to 19a-7d, inclusive,
2445 subsection (a) of 19a-59b, subsection (b) of section 38a-552, subsection
2446 (d) of section 38a-556 and sections 38a-564 to 38a-573, inclusive, and
2447 shall make interim reports to the General Assembly on its findings by
2448 January 15, 1991, and by February 1, 1992, and a final report on such
2449 findings by February 1, 1993.] The commission shall make
2450 recommendations to the General Assembly on any legislation
2451 necessary to further the attainment of the goal described in section 19a-
2452 7a.

2453 Sec. 34. Subsection (a) of section 31-51o of the general statutes is
2454 repealed and the following is substituted in lieu thereof (*Effective from*
2455 *passage*):

2456 (a) Whenever a relocation or closing of a covered establishment
2457 occurs, the employer of the covered establishment shall pay in full for
2458 the continuation of existing group health insurance, no matter where
2459 the group policy was written, issued or delivered, for each affected
2460 employee and his dependents, if covered under the group policy, from
2461 the date of relocation or closing for a period of one hundred twenty
2462 days or until such time as the employee becomes eligible for other
2463 group coverage, whichever is the lesser, provided any right of such
2464 employee and his dependents to a continuation of coverage, as
2465 required by section [38a-538 or 38a-554] 38a-512a, as amended by this

2466 act, shall not be affected by the provisions of this section, and provided
2467 further the period of continued coverage required by said sections
2468 shall not commence until the period of continued coverage established
2469 by this section has terminated.

2470 Sec. 35. Section 38a-472d of the general statutes is repealed and the
2471 following is substituted in lieu thereof (*Effective from passage*):

2472 (a) Not later than January 1, 2006, the Insurance Commissioner, in
2473 consultation with the Commissioner of Social Services and the
2474 Healthcare Advocate, shall develop a comprehensive public education
2475 outreach program to educate health insurance consumers about the
2476 availability and general eligibility requirements of various health
2477 insurance options in this state. The program shall maximize public
2478 information concerning health insurance options in this state and shall
2479 provide for the dissemination of such information on the Insurance
2480 Department's Internet web site.

2481 (b) The information on the department's Internet web site shall
2482 reference the availability and general eligibility requirements of (1)
2483 programs administered by the Department of Social Services,
2484 including, but not limited to, the Medicaid program and the HUSKY
2485 Plan, Part A and Part B, (2) health insurance coverage provided by the
2486 Comptroller under subsection (i) of section 5-259, as amended by this
2487 act, [(3) health insurance coverage available under comprehensive
2488 health care plans issued pursuant to part IV of this chapter, and (4)]
2489 and (3) other health insurance coverage offered through local, state or
2490 federal agencies or through entities licensed in this state. The
2491 commissioner shall update the information on the web site at least
2492 quarterly.

2493 Sec. 36. Subsection (b) of section 38a-480 of the general statutes is
2494 repealed and the following is substituted in lieu thereof (*Effective from*
2495 *passage*):

2496 (b) [The] Except as otherwise provided in this title, the provisions of

2497 sections 38a-481 to 38a-488, inclusive, as amended by this act, 38a-492,
 2498 38a-502 and 38a-505, as amended by this act, shall not apply to any
 2499 subscriber contract issued by a health care center.

2500 Sec. 37. Section 38a-573 of the general statutes is repealed and the
 2501 following is substituted in lieu thereof (*Effective from passage*):

2502 If any provision of [sections] section 38a-564, as amended by this
 2503 act, [to 38a-572, inclusive] 38a-566, as amended by this act, 38a-567, as
 2504 amended by this act or 38a-569, as amended by this act, is held invalid,
 2505 the invalidity shall not affect other provisions of said sections [which]
 2506 that can be given effect without the invalid provisions.

2507 Sec. 38. Sections 38a-538, 38a-553 to 38a-555, inclusive, 38a-565, 38a-
 2508 568 and 38a-570 to 38a-572, inclusive, of the general statutes are
 2509 repealed. (*Effective from passage*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>from passage</i>	38a-183(a)
Sec. 2	<i>from passage</i>	38a-199
Sec. 3	<i>from passage</i>	38a-208
Sec. 4	<i>from passage</i>	38a-214
Sec. 5	<i>from passage</i>	38a-218
Sec. 6	<i>from passage</i>	38a-481
Sec. 7	<i>from passage</i>	38a-513(a) and (b)
Sec. 8	<i>from passage</i>	38a-476
Sec. 9	<i>from passage</i>	38a-478g(a)
Sec. 10	<i>from passage</i>	38a-505
Sec. 11	<i>from passage</i>	38a-512a
Sec. 12	<i>from passage</i>	38a-537
Sec. 13	<i>from passage</i>	38a-551
Sec. 14	<i>from passage</i>	38a-552
Sec. 15	<i>from passage</i>	38a-556
Sec. 16	<i>from passage</i>	38a-557
Sec. 17	<i>from passage</i>	38a-564
Sec. 18	<i>from passage</i>	38a-566

Sec. 19	<i>from passage</i>	38a-567
Sec. 20	<i>January 1, 2016</i>	38a-567(2)(C)
Sec. 21	<i>from passage</i>	38a-569
Sec. 22	<i>from passage</i>	38a-574
Sec. 23	<i>from passage</i>	38a-543
Sec. 24	<i>from passage</i>	5-248a(f)
Sec. 25	<i>from passage</i>	5-259(i)
Sec. 26	<i>from passage</i>	12-201(7)
Sec. 27	<i>from passage</i>	12-211(c)
Sec. 28	<i>from passage</i>	12-212a
Sec. 29	<i>from passage</i>	17b-265(e)
Sec. 30	<i>from passage</i>	17b-284(c)
Sec. 31	<i>from passage</i>	17b-299(c)(6)
Sec. 32	<i>from passage</i>	17b-611(b)
Sec. 33	<i>from passage</i>	19a-7b(b)
Sec. 34	<i>from passage</i>	31-51o(a)
Sec. 35	<i>from passage</i>	38a-472d
Sec. 36	<i>from passage</i>	38a-480(b)
Sec. 37	<i>from passage</i>	38a-573
Sec. 38	<i>from passage</i>	Repealer section

Statement of Purpose:

To (1) update the health insurance statutes to reflect changes in federal law, (2) give the Insurance Department the authority to approve small employer group health insurance rates, and (3) specify that health insurance policies may not reduce payments on the basis that an individual is eligible for Medicare unless such individual enrolls in Medicare.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]